



# **CS-19 Afghanistan Detailed Implementation Plan Draft**

*Provincial Strengthening in Northern Afghanistan:  
Capacity Building and Innovation to Support the Basic Package of Health  
Services and Sustainably Improve Access, Quality and Use of Essential  
MCH Services throughout Jawzjan Province*

Standard Child Survival and Health Grant  
Cooperative Agreement No.: GHS-A-00-03-00011-00  
September 30, 2003 – September 29, 2008, in  
Jawzjan Province of Northern Afghanistan

Submitted to USAID/GH/HIDN  
April 30, 2004

Principal contributors: Ms. Kathryn Bolles, Child Survival Specialist; Dr. Tariq Ihsan, Asia Regional Health Advisor; Dr. Honey Mukhtar, Senior Project Manager; Dr. Eric Starbuck, Child Survival Specialist; and Ms. Carmen Weder, Manager.

## Table of Contents

Glossary of Acronyms and Terms.....	4
A. Executive Summary.....	7
B. CSHGP Data Form.....	9
C. Project Design Process and Start-Up Activities.....	14
D. Revisions from the Original Application.....	18
E. Detailed Implementation Plan.....	22
1. Summary of Baseline and Other Assessments.....	22
2. Program Description by Objective, Intervention, and Activity.....	40
3. Program Monitoring and Evaluation Plans.....	60
4. Work Plan (Tables).....	65
F. Annexes.....	82
1. Response to Application Debriefing.....	83
2. Reports of Baseline Assessments.....	95
a) KPC Survey Andkhoy.....	95
b) KPC Survey Jawzjan.....	110
c) IFHA Report: Andkhoy Cluster.....	167
d) IFHA Report: Jawzjan Province.....	203
e) Report on Breastfeeding Research.....	239
f) Focus Group Discussions.....	288
g) Gap Analysis.....	290
3. Revised Agreement Between SC and MOH Jawzjan.....	307
4. DIP Workshop Agenda and Participants .....	310
5. Map of Afghanistan and CS-19 Site.....	312
6. SC CS-19 Afghanistan Revised Organizational Chart .....	313
7. Diagram of CS-19 and related MOH and REACH counterparts.....	314
8. Resumes/CVs of Key Personnel (revisions from original application).....	315
a) Ms. Kathryn Bolles.....	315
b) Dr. Honey Mukhtar.....	317
c) Ms. Kim Allen.....	319
9. Rapid CATCH Summary Data.....	322
10. PHO Terms of Reference.....	324
11. Supervisory Checklist Sample.....	326

## **DIP Tables and Figures (Excluding Annexes)**

Table 1.	REACH-Funded Facilities.....	14
Table 2.	Jawzjan KPC Survey Questions.....	25
Table 3.	Indicators, Methods, Baseline Values and Corresponding Interventions for Andkhoy Cluster.....	29
Table 4.	Indicators, Methods, Baseline Values and Corresponding Interventions for Jawzjan Province.....	31
Table 5.	Nutritional Status Assessment.....	36
Table 6.	Caregiver Counseling Received.....	37
Table 7.	CS-19 Goal, Strategic Objective, Intermediate Results, Interventions, and Major Strategies.....	39
Table 8.	CS-19 Supported Clinics.....	49
Table 9.	CS-19 BCC Activities by Audience.....	52
Table 10.	CS-19 Results, Indicators, Measurement Methods and Frequencies, Baseline Values and End of Project Targets for Jawzjan Province.....	65
Table 11.	CS-19 Results, Indicators, Measurement Methods and Frequencies, Baseline Values and End of Project Targets for Andkhoy Cluster.....	68
Table 12.	CS-19 Work Plan of Activities by Intervention.....	71
Figure 1.	CS-19 Intervention Areas.....	39

## Glossary of Acronyms and Terms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ARI	Acute Respiratory Infections
BASICS	Basic Support for Institutionalizing Child Survival (USAID-supported Project)
BC	Behavior Change
BCC	Behavior Change Communication
BCG	Bacille Calmette-Guerin/Tuberculosis Vaccine
BEOC	Basic Emergency Obstetric Care
BHC	Basic Health Center
BPHS	Basic Package of Health Service
C	Celsius
CBO	Community Based Organization
CCAR	Chief Commissioner for Afghan Refugees
CCM	Community Case Management
CDC	U.S. Centers for Disease Control and Prevention
CDD	Control of Diarrheal Disease
CDQ	Community Defined Quality (SC methodology which is the same as PDQ)
CEOC	Comprehensive Emergency Obstetrical Care
CFR	Case Fatality Rate
CHC	Comprehensive Health Center
CHC	Community Health Committee
CHW	Community Health Worker
CS	Child Survival
CS-19	The program, <i>Provincial Strengthening in Northern Afghanistan: Capacity Building and Innovation to Support the Basic Package of Health Services and Sustainably Improve Access, Quality and Use of Essential MCH Services throughout Jawzjan Province</i> , funded in large part through the 19 <sup>th</sup> cycle of the PVO CSH Grants Program which began in October 2003, is referred to as “CS-19”.
CSHGP	Child Survival and Health Grants Program of USAID
CTO	Coordination Technical Officer
DD	Diarrheal Diseases
DH	District Hospital
DIP	Detailed Implementation Plan
DMPA	Injectable Contraception (Depo-Provera)
DPT	Diphtheria-Pertussis-Tetanus Immunization

EPI	Expanded Program on Immunization
FGD	Focus Group Discussion
FP	Child Spacing/Family Planning (“FP” is used in order to not confuse “CS” with “child survival.”)
GAT	Gap Analysis Tool
GMP	Growth Monitoring and Promotion
HE	Health Education
HF	Health Facility
HFA	Health Facility Assessment (interchangeable with IHFA)
HFA	Height for Age
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HP	Health Post
ICRC	International Committee of the Red Cross
IEC	Information, Education and Communication
IHFA	Integrated Health Facility Assessment
IMCI	Integrated Management of Childhood Illness
IMPAC	Integrated Management of Pregnancy and Childbirth
IR	Intermediate Result
IUD	Intra-Uterine Device
IV	Intravenous
KPC	Knowledge, Practices, and Coverage (CSHGP-related survey tool)
LAM	Lactational Amenorrhea Method
MCH	Maternal and Child Health
M&E	Monitoring and Evaluation
MNC	Maternal and Newborn Care
MOH	Ministry of Health
MSH	Management Sciences for Health
<i>Mullah</i>	Religious Leader
NB	Newborn
NCHS	National Center for Health Statistics
NGO	Non-Governmental Organization
NID	National Immunization Day
OB/GYN	Obstetrics/Gynecology
OPD	Outpatient Department

OPV	Oral Polio Vaccine
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
PD	Positive Deviance
PDI	Positive Deviance Inquiry
PHCC	Provincial Health Coordination Committee
PHO	Provincial Health Office
PNC	Prenatal Care
PPC	Post-Partum Care
PRA	Participatory Rapid Appraisal
PVO	Private Voluntary Organization
QA	Quality Assurance
R	Recommendation
R	Result
REACH	Rural Expansion of Afghanistan's Community Based Healthcare
RH	Reproductive Health
SC	Save the Children (US)
SCF	Save the Children Fund (UK)
SD	Standard Deviation
SM	Safe Motherhood
SO	Strategic Objective
STD	Sexually Transmitted Disease
TB	Tuberculosis
TBA	Traditional Birth Attendant
TOT	Training of Trainers
TT	Tetanus Toxoid Vaccine
TT2	Tetanus Toxoid, second dose
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nation's Children's Fund
USAID	United States Agency for International Development
VitA	Vitamin A
WHO	World Health Organization
WHZ	Weight for Height Z-score
WRA	Women of Reproductive Age

## A. EXECUTIVE SUMMARY

The past years of conflict and recent drought have devastated Afghanistan, destroyed much of its economy, and dislocated large numbers of people. Estimates of under-five mortality in Afghanistan are among the highest in the world, ranging from 257 to 279 deaths per 1,000 live births. WHO, UNICEF, and UNFPA estimate that the maternal mortality ratio in Afghanistan in 2000 was approximately 1,900 per 100,000 live births, with a high total fertility rate of 6.8 contributing to a lifetime risk of death due to pregnancy-related causes of approximately one in six. A recent UNICEF/CDC reproductive age mortality survey in four urban and rural areas of the country found a maternal mortality ratio of 1,600.

The dramatic political changes in the past few years have brought hope to the people of Afghanistan, and are beginning to be translated into substantial improvements in the health system. In Jawzjan Province in northern Afghanistan, most MOH MCH services in rural areas have been provided through Basic Health Centers (BHCs), which deliver curative care in the province's 14 districts. The recent adoption of the Basic Package of Health Services (BPHS) for Afghanistan by the MOH, NGOs, UN organizations and other partners will offer a comprehensive list of services at four levels of health facilities: the Health Post, BHC, Comprehensive Health Center (CHC), and the District Hospital. Priority components of the BPHS include MNC, EPI, IMCI, child nutrition, and control of TB and malaria.

In accordance with this new national policy, CS-19 plans to support the BPHS, which will be implemented through The Rural Expansion of Afghanistan's Community Based Healthcare (REACH), a 3-year program supported by USAID, and implemented through Management Sciences for Health (MSH.) REACH objectives align with the CS-19 strategic objective and intermediate results, focusing on increasing knowledge, use, access, and quality of services for women of reproductive age and children under 5, particularly in underserved communities. Additionally, REACH funds will support new facilities and staff at both the community and the district level. In Jawzjan Province, CS-19 will support these activities by developing the technical capacity and improving health delivery systems at the provincial level, including supporting the Provincial Health Office technical staff, not covered within the REACH Program.

SC is well positioned to support the BPHS through CS-19, given the history of successful SC programs in Afghanistan and the technical capacity building and innovation that SC can offer to complement the new health policy. SC has been working in Afghanistan since 1989 and with the MOH in Jawzjan province since 1995, where SC has supported the MOH in the Andkhoy cluster of four districts to increase access to and the quality and use of essential MCH services at BHCs and through outreach workers and health volunteers. In Shiberghan, the provincial center, SC has trained and supported provincial hospital staff to provide standard case management of childhood diarrhea and ARI, and through health volunteers, has educated caretakers to promptly recognize and seek care for children with pneumonia and severe diarrhea, and care for non-severe diarrhea in the home. SC has also partnered with WHO, UNICEF, and local NGOs to support EPI and vitamin A supplementation in the three neighboring provinces of Faryab, Jawzjan, and Sar-i Pul.

The **goal** of CS-19 is to achieve a sustained reduction in under-five and maternal mortality in Jawzjan, which will be met through the achievement of the following **strategic objective and intermediate results**:

- SO: Improved health practices at the household level, and increased use of essential MCH services;
- IR-1: Increased household-level knowledge of essential MCH practices in Jawzjan Province;

- IR-2: Increased access to essential MCH services in Jawzjan province;
- IR-3: Increased quality of essential MCH services in Jawzjan Province; and
- IR-4: Established social network to support key behaviors.

These results will be achieved through support to the MOH in Jawzjan, in the following key intervention areas:

1. Immunization (EPI, 20% of estimated intervention-specific project effort);
2. Nutrition (Nut, 15%);
3. Control of Diarrheal Diseases (CDD, 15%);
4. Pneumonia Case Management (ARI, 20%); and
5. Maternal and Newborn Care (MNC, 30%).

These interventions will be implemented through the following four major cross-cutting **strategies**:

1. Provincial-level strengthening of the MOH in Jawzjan through training, capacity-building of the PHO, and supervision to effectively support the BPHS;
2. Health behavior change activities through health facility staff, CHWs, mullahs, teachers, midwives, mothers-in-law, and local radio;
3. CS-19 engagement with health sector partners to leverage resources in support of essential MCH activities in Jawzjan; and
4. Testing innovative approaches to improving access, quality, and use of essential MCH services; documentation and dissemination of feasibility and results; and scaling-up of successful approaches:
  - Community Defined Quality (CDQ): Working with community members and health staff to understand and improve the quality of MCH services from the community perspective, and to increase use of essential health services by community members; and
  - Community Case Management (CCM): Increasing community access to and prompt use of life-saving treatment for childhood diarrhea and pneumonia by training and supporting CHWs to provide this service in areas with poor access.

The CS-19 strategies and interventions will build upon and expand SC's work in Jawzjan, through close collaboration with the MOH, throughout all of Jawzjan Province, in a total population of approximately 707,500, including 280,000 potential beneficiaries, of which 124,200 are children under five and 155,800 are women 15 to 49 years of age. The CS-19 program is funded from September 30, 2003 through September 29, 2008, in the standard category of the CSHGP, with \$1,500,000 from USAID and matched with \$500,000 from SC. SC has discussed the CS-19 design with Ms. Elizabeth Kvitashvili, former General Development Officer, and discussed design and planned revisions with Ms. Ellen Lynch, Population, Health and Nutrition Officer from the USAID Mission to Afghanistan.

Principal authors of this Draft DIP are: Dr. Tariq Ihsan, Regional Health Officer, SC, Islamabad; Dr. Honey Mukhtar, CS-19 Health Coordinator, SC, Afghanistan; and Ms. Kathryn Bolles, Child Survival Specialist, one of the two contact persons for CS-19 in the Office of Health at SC in Westport, CT, along with Ms. Carmen Weder, Manager.



## B. CSHGP DATA FORM

### Field Contact Information:

First Name: Dr. Aftab Tariq  
Last Name: Ihsan  
Address: P.O. Box 1952, House No. 5, Street # 29, F -7/1  
City: Islamabad  
Country: Pakistan  
Telephone: (011-92-512) 559-3631, 559-1100  
Fax:  
E-mail: [aftabtariq56@yahoo.com](mailto:aftabtariq56@yahoo.com)

### Project Information:

**Project Description:** This five-year Child Survival Program, *Provincial Strengthening in Northern Afghanistan: Capacity Building and Innovation to Support the Basic Package of Health Services in Jawzjan Province*, builds upon Save the Children's (SC) work in Afghanistan since 1989, where SC has supported the MOH in the Andkhoy cluster of four districts to increase access to, quality and use of essential MCH services at basic health facilities and community health posts. Significant health policy change in the last year has brought about the adoption of the Basic Package of Health Services (BPHS) for Afghanistan, which will offer a comprehensive list of MCH services at all levels of care. In accordance with this new national policy, CS-19 plans to support the BPHS, which will be implemented through The Rural Expansion of Afghanistan's Community Based Healthcare (REACH), a three-year program supported by USAID, and implemented through Management Sciences for Health. In Jawzjan Province, CS-19 will support these activities by developing the technical capacity and improving health delivery systems at the provincial level, including supporting the Provincial Health Office technical staff, not covered within the REACH Program.

SC is well-positioned to support the BPHS through CS-19, given the history of successful SC programs in Afghanistan and the technical capacity-building and innovation that SC can offer to complement the new health policy. The goal of CS-19 is to achieve a sustained reduction in under-five and maternal mortality in Jawzjan, which will be met through the achievement of the following strategic objective and intermediate results:

SO: Improved health practices at the household level, and increased use of essential MCH services;  
IR-1: Increased household-level knowledge of essential MCH practices in Jawzjan Province;  
IR-2: Increased access to essential MCH services in Jawzjan Province;  
IR-3: Increased quality of essential MCH services in Jawzjan Province; and  
IR-4: Established social network to support key behaviors.

These results will be achieved through support to the MOH in Jawzjan, in the following key intervention areas: Immunization (20%); Nutrition (15%); Control of Diarrheal Diseases (15%); Pneumonia Case Management (20%); and Maternal and Newborn Care (30%).

These interventions will be implemented through the following four major cross-cutting strategies:

1. Provincial-level strengthening of the MOH in Jawzjan through training, capacity-building of the PHO, and supervision to effectively support the BPHS;
2. Health behavior change activities through health facility staff, CHWs, TBAs, mullahs, teachers, children, and local radio;
3. SC/MOH engagement with health sector partners to leverage resources in support of essential MCH activities in Jawzjan; and
4. Testing innovative approaches to improving access, quality, and use of essential MCH services; documentation and dissemination of feasibility and results; and scaling-up of two successful approaches (Community Case Management, and Community Defined Quality.)

**Partners:** The MOH in Jawzjan Province and Management Sciences for Health (MSH) through the REACH Program.

**Project Location:** Jawzjan Province, including the Andkhoy Cluster, in Northern Afghanistan.

**Target Beneficiaries:**

Type	Number
Infants (0-11 months):	24,840
12-23 month old children:	17,610
24-59 month old children:	81,750
0-59 month old children:	124,200
Women 15-49 years old:	155,800
Estimated Number of Births:	111,780

**Beneficiary Residence:**

Urban/Peri-Urban %	Rural %
5	95

**Grant Funding Information:**

USAID Funding:(US \$)	\$1,500,000	PVO match:(US \$)	\$ 500,000
-----------------------	-------------	-------------------	------------

**General Strategies Planned:**

Strengthen Decentralized Health System

**M&E Assessment Strategies:**

KPC Survey

Health Facility Assessment

Community based Monitoring Techniques

Participatory Rapid Appraisal

Participatory Evaluation Techniques (for midterm and final evaluation)

**Behavior Change & Communication (BCC) Strategies:**

Interpersonal Communication

Mass Media

CS-19 Afghanistan: *Provincial Strengthening*. DIP Draft. Save the Children, April 2004.

Peer Communication

**Capacity Building Targets Planned:**

<b>PVO</b>	<b>Non-Govt Partners</b>	<b>Other Private Sector</b>	<b>Govt</b>	<b>Community</b>
Field Office HQ CS Project Team	PVOs Local NGO Networked Group	Pharmacists Traditional Healers	Nat'l MOH District Health System Health Facility Staff	Health CBOs Other CBOs CHWs

**Interventions:**

<b>Immunization 20%</b>
Cold Chain Strengthening
HF Training
CHW training
Classic 6 Vaccines
Surveillance
<b>Acute Respiratory Infection 20%</b>
Pneumonia Case Management
IMCI Integration
Case Management Counseling
CHW Training
HF Training
Recognition of ARI Danger Signs
<b>Control of Diarrheal Diseases 15%</b>
Care Seeking
IMCI Integration
Hand Washing
Case Management/Counseling
CHW Training
ORS/Home Fluids
HF Training
Feeding/Breastfeeding
<b>Nutrition/Micronutrients/Vit A (Combined) 15%</b>
HF Training
CHW Training
Comp. Feed. from 6 mos.
Cont. BF up to 24 mos.
Growth Monitoring

Iodized Salt
Integrated with EPI
Hearth
Postpartum
<b>Maternal &amp; Newborn Care 30%</b>
HF Training
Emergency Obstetrical Care
Recognition of Danger signs
Newborn Care
Postpartum Care
Integr. with Iron & Folate
Normal Delivery Care
Delay 1 <sup>st</sup> pregnancy Child Spacing
CHW Training
Birth Plans
Neonatal Tetanus

**Rapid CATCH indicators:**

#	CATCH Indicators	N/D	%	Confidence Limits	
				No Design Effect	Design Effect of 2
1	Percentage of children age 0–23 months who are underweight (-2 SD from the median weight-for-age, according to the WHO/NCHS reference population)	152/270	56%	± 6%, or between 50% and 62%.	± 8%, or between 48% and 64%.
2	Percentage of children age 0–23 months who were born at least 24 months after the previous surviving child	38/81	47%	± 11%, or between 36% and 58%.	± 15%, or between 32% and 62%.
3	Percentage of children age 0–23 months whose births were attended by skilled health personnel	84/300	28%	± 5%, or between 23% and 33%.	± 7%, or between 21% and 35%.
4	Percentage of mothers with children age 0–23 months who received at least two tetanus toxoid injections before the birth of their youngest child	44/300	15%	± 4%, or between 11% and 19%.	± 6%, or between 9% and 21%.
5	Percentage of children age 0–5 months who were exclusively breastfed during the last 24 hours	49/72	68%	± 11%, or between 57% and 79%.	± 15%, or between 53% and 83%.
6	Percentage of children age 6–9 months who received breast milk and complementary foods during the last 24 hours	22/66	33%	± 11%, or between 22% and 44%.	± 16%, or between 17% and 49%.
7	Percentage of children age 12–23 months who are fully vaccinated	6/142	4%	± 3%, or between 1% and 7%.	± 5%, or between 0% and 9%.

	(against the five vaccine-preventable diseases) before the first birthday			and 7%.	and 9%.
8	Percentage of children age 12–23 months who received a measles vaccine	17/142	12%	$\pm 5\%$ , or between 7% and 17%.	$\pm 8\%$ , or between 4% and 20%.
9	Percentage of children age 0–23 months who slept under an insecticide-treated net (in malaria risk areas) the previous night.	131/300	44%	$\pm 6\%$ , or between 38% and 50%.	$\pm 8\%$ , or between 36% and 52%.
10	Percentage of mothers with children age 0–23 months who cite at least two known ways of reducing the risk of HIV infection.	0/300	0%	N/A	N/A
11	Percentage of mothers with children age 0–23 months who report that they wash their hands with soap/ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated.	50/300	17%	$\pm 4\%$ , or between 13% and 21%.	$\pm 6\%$ , or between 11% and 23%.
12	Percentage of mothers of children age 0–23 months who know at least two signs of childhood illness that indicate the need for treatment.	43/300	14%	$\pm 4\%$ , or between 10% and 18%.	$\pm 6\%$ , or between 8% and 20%.
13	Percentage of sick children age 0–23 months that received increased fluids and continued feeding during an illness in the past two weeks.	14/205	7%	$\pm 3\%$ , or between 4% and 10%.	$\pm 5\%$ , or between 2% and 12%.

#### Notes on CATCH indicator table:

1. We have used the following formula to calculate the Confidence Limits:  $P = p \pm Z \times \text{the square root of } (pq/n')$ , where  $P$  = the true proportion of the population;  $Z$  = 95% confidence (1.96);  $p$  = the proportion found in the survey;  $q = 1 - p$ ; and  $n'$  = the size of the sample divided by the design effect. As suggested on page 9 in “Writing the KPC Report” of the KPC 2000+ Manual, we have computed each indicator two ways: without the design effect and with a design effect of 2 to account for the potential intra-cluster correlation resulting from the use of cluster sampling. Therefore, it can be said for the first indicator that “We are 95% confident that the true proportion of the population is between 48% and 64%. The best estimate for the true proportion of the population is 56%.”

2. The KPC survey conducted in the four districts of the Andkhoy cluster in January 2003 (nine months prior to CS-19 start-up) measured eight of the CATCH indicators. Indicator 1 (% underweight), 2 (spacing), 9 (bednets), and 11 (HIV knowledge) were not measured. Indicator 12 (knowledge of signs of illness indicating need for treatment) was not measured in relation to childhood illness in general, but maternal knowledge of signs of childhood diarrhea and ARI indicating the need for treatment was measured. The November 2003 KPC survey covering the areas of Jawzjan Province excluding the Andkhoy cluster measured all 13 CATCH indicators. These indicators are presented in the table above.

## C. DESCRIPTION OF DIP PREPARATION PROCESS

### Background information

The CS-19 design and proposal development took place in consultation with MOH staff based in Jawzjan Province, MOH Kabul, USAID Mission/Kabul, and UNICEF. In March 2003, after the submission and approval of the proposal, the Afghan MOH developed a new set of priorities for rebuilding the national health system and making crucial services available to all Afghans, especially those living in remote and underserved areas. This set of services, called a Basic Package of Health Services (BPHS), is an integrated model of key services chosen by MOH officials, international UN agencies, NGOs, donors, and other stakeholders in the health sector. The MOH expects all NGOs delivering health services to consider the BPHS as the official policy of Afghanistan and to provide these core services before any others. Subsequently, the MOH, with the help of MSH, UNICEF and WHO, developed the Rural Expansion of Afghanistan's Community Based Healthcare Program (REACH), coordinated through MSH, as the approach by which all NGOs and other health providers will implement the national BPHS. These services will be offered at four types of facilities, identified in Table X below. In Jawzjan Province, there are approximately X health posts, 13 BHCs (4 existing and 6 new MOH facilities, and 3 non-MOH), 10 CHCs, and 2 District Hospitals.

**Table 1. REACH-Funded Facilities**

Facility Level	Minimum Staff	Population Coverage
Health Post	Community Health Worker, Traditional Birth Attendant	1,000-1,500
Basic Health Center	Nurse (male), Midwife/Auxiliary Midwife, Vaccinator	15,000-30,000
Comprehensive Health Center	2 Doctors (m/f), Midwife, 2 nurses (m/f), Lab Tech Pharmacist, Vaccinator, Administrator	30,000-60,000
District (First Referral) Hospital	2 Doctors (m/f), surgeon, anesthetist, Pediatrician, Midwife, nurse, X-ray tech, Lab Tech, Pharmacist, Vaccinator, Dentist, Dental Tech, Administrator	100,000-300,000

Source: USAID MOH REACH Grants Program

The REACH Program identifies the following objectives in support of the MOH goal of BPHS implementation:

### EXPANDING SERVICE DELIVERY SYSTEMS:

- Expanding and enhancing service coverage for women of reproductive age and children (under age 5) to address the most common causes of mortality and morbidity.
- Increasing the number of health facilities and strengthening them to deliver the full Basic Package of Health Services promoted by the MOH.
- Developing health service delivery systems at the community level, including community outreach and appropriate referral centers.

## IMPROVING QUALITY OF SERVICES:

- Improving the quality and utilization of existing health services.
- Increasing the number of trained, supplied and supervised clinical staff and community health workers, especially women.

## INCREASING CAPACITY:

- Increasing the capacity of the NGOs and provincial health departments to collect and utilize health and financial management data.
- Supporting the capacity of NGOs and provincial health department to use health and financial data for making resource allocation decisions and managing resources.
- Increasing the managerial capacity of the NGOs and provincial health departments to promote sustainable and cost-effective health service delivery to communities.

Beginning in October 2003, SC CS-19 staff and partners commenced planning the revisions to the CS-19 design in accordance with the REACH activities and in order not to duplicate services planned for Jawzjan Province through the BPHS. Although REACH is a three-year funded project and CS-19 is a five-year project, REACH monies will bring needed resources into all provinces, including Jawzjan, which will sustain staff and activities beyond the project funding period. In addition, many expect REACH to receive funding for a second cycle after the initial three years. REACH support for the BPHS is concentrated on providing and enhancing the quality of services at the community and district level, so planning discussions for CS-19 focused on filling in the gaps that were beyond the scope of REACH at the provincial level, which would complement and enhance REACH and BPHS. Revisions are discussed in the following section.

### Start up activities

#### *1. Orientation session*

In October 2003, the CS-19 Coordinator and the SC Asia Area Health Advisor conducted a one-day orientation session with key MOH staff to discuss the official start-up date of CS-19, review the key interventions, approaches, and target areas; and to begin initial conversations regarding the need for revisions. Participants in this session were the following: Dr. Haroon, Provincial Health Director, MOH Jawzjan; Dr. Rehmatullah, MOH director Andkhoy; Dr. Mina MOH MCH female physician; Dr. Dilsouz, MOH physician; Dr. Khalil, MOH pediatrician, and Dr. Nazaqat, MOH female OB/GYN/MOH Deputy Director.

#### *2. Staff recruitment and changes*

- A. Job descriptions were created and a recruitment process started for the four CS-19 positions who will work directly with the MOH counterparts at the Provincial Health Office for Jawzjan. These positions are: RH Officer, EPI Officer, CDD/ARI Officer, and BCC Officer. Additionally, a job description for 10 MCH Promoters was created. These promoters will be based in communities across Jawzjan, working at health facilities and with CHWs at health posts.
- B. The CS-19 Coordinator, Dr. Iqbalshah Pakzad, left the position to work with MSH in implementing REACH in Jawzjan. Dr. Honey Mohammed (refer to his CV in the Annex section) was promoted from the SC CDD/ARI Coordinator to CS-19 Coordinator. Although

SC lost an exemplary employee with Dr. Iqbalshah's leaving, he continues to support CS-19 through his association with MSH/REACH, which has developed an even stronger alliance and working relationship between the two projects.

### *3. Baseline studies*

In November 2004, the CS-19 coordinator with the help of Asia Area Health Advisor planned baseline studies as outlined in the CS19 proposal. Four types of baselines studies were planned and three types were completed by the end of January 2004. These baseline studies were the following:

- Two Integrated Health Facility Assessments (IHFA), using USAID/BASICS tools;
- Two Knowledge, Practice and Coverage (KPC) surveys;
- Thirty Focus Group Discussions (FGD) exploring health seeking behaviors, barriers and possible solutions; and
- A Gap Analysis (GA), a tool to assess gaps in the Safe Motherhood service provision.

Integrated facility health assessments (IFHA) were conducted in the Andkhoy cluster and in all districts of Jawzjan province, covering a total of eighteen health facilities, including eleven BHCs, two OPDs of district hospitals, one CHC, two MCH clinics, one health post, and the pediatric department of the provincial hospital. Two health facilities were excluded in Shiberghan; one was deselected because of its location near the airport and the lack of villages within its catchment area, and the other because it did not provide curative services to children under five. Four IFHA questionnaires developed by USAID/BASICS (1.Observation Checklist – Sick Child, 2.Exit Interview – Sick Child, 3.Health Care Worker Interview, and 4.Equipment and Supplies Checklist) were used.

The assessment team included four SC/US IMCI trained doctors, four MOH senior doctors and seven MOH female nurses. The doctors were responsible for implementing the observation checklist, the health worker interviews, and the supply/equipment checklists, and the nurses implemented the exit interviews with caregivers. The Asia Area Health Advisor and other senior SC health staff provided three days of training for the assessment team from December 4-6, 2003, followed by a two day field-test and field-based training.

A thirty-cluster KPC survey was also implemented in Jawzjan province using a systematic random sampling technique. A total of 300 mothers with children between 0-23 months were sampled and interviewed to measure the baseline indicators. An external consultant based in the US adapted the KPC questionnaire based on KPC+ 2000 modules. The survey team consisted of sixteen local female schoolteachers who were trained and supervised by four senior SC and four senior MOH staff, with the Asia Area Health Advisor providing the overall technical assistance and guidance. The training was conducted over a period of four days, followed by a two day field-test and further training at the field sites. The survey was conducted over six days. Three data entry staff were trained on data entry in EPI-INFO 6.4, and data entry was carried out for a period of seven days.

One of the recommendations from the KPC findings was a need for FGD to further understand barriers to health seeking (particularly immunization, family planning and safe motherhood services), learn about birth preparedness/planning practices, understand why family planning use is so low and explore ways to increase access to FP services. Further recommendations for qualitative methods highlighted the need to understand the local terms used to describe childhood illnesses, and to gain more information surrounding home care and health-seeking practices. The assessment team developed three checklists to target different community members and to elicit information around



these key issues. A two-day refresher training was given to six female and four male trained schoolteachers and health workers in Andkhoy cluster, and a three-day training on participatory rapid appraisal (PRA) techniques was given to six female schoolteachers and nurses, and four male health workers in Jawzjan. FGD exercises were carried out for a period of four days with support from SC and MOH senior health staff. A total of 288 community members participated in 32 focus group discussions in Andkhoy and Jawzjan. Participants included mothers with children under six months old; mothers and fathers with children 6-24 months old; and women and men who participated in the family planning discussions. Data is still being coded and analyzed at the time of the writing of this document, and the final report is scheduled for the end of June 2004.

The three levels in the "Household to Hospital Continuum of Care" are a) the household; b) the periphery and its facilities, which include community health centers, basic health centers, MCH units, and private maternity homes, and c) the district hospital or referral facility. SC's Office of Health's RH advisor suggested using the Gap Analysis tool to investigate services that should/could be available (per protocol and evidence base), to identify existing gaps contributing to maternal and newborn death and disability, and to make recommendations on how to improve existing services. At this time, the Gap Analysis has been conducted at the first level of the continuum of care, and completion of this activity is expected for July 2004, when additional female staff are in place.

#### *4. DIP Development*

The first priority of the DIP planning process was for all stakeholders in CS-19 (MOH Jawzjan, USAID/Kabul, MSH/REACH, UNICEF, and local and international NGOS providing health services in Jawzjan) to reach an accord in the re-design of the CS-19 interventions and approaches. An initial meeting with Dr. Haroon, MOH Provincial Health Director, took place in February 2004 to plan the DIP workshop in which all stakeholders could discuss revisions to CS-19 and to extend invitations to approximately 40 representatives from organizations providing services within the province. The Child Survival Specialist from SC Westport, the CS-19 Coordinator, and the Asia Area Health Advisor met in Jawzjan Province on March 7, 2004 and began planning the workshop, in collaboration with the Provincial Health Committee. The workshop agenda and list of participants are found in Annex 6. The two-day workshop took place on March 10-11, 2004, and was preceded by two planning days with the SC CS-19 staff and the CS Specialist, including a field visit to Andkhoy to meet with Dr. Rehmatullah, the MOH director, and to visit the newly rebuilt SC MCH clinic.

The DIP workshop objective was to reach agreement and support for CS-19; therefore, all organizations working in the area under REACH or providing health services in Jawzjan were asked to attend, and 36 participants from 10 organizations attended. After the workshop, the CS-19 team met again with the Provincial Health Director to refine the new design and agree on additional provincial level support that he requested from CS-19 that is outside of REACH funding. Finally, the CS-19 staff held additional meetings in Jawzjan with MSH/REACH, and responded to questions regarding CS-19 avoiding duplications with REACH activities, and filling in technical and health service delivery gaps at the provincial level. Finally, the CS Specialist, Asia Area Health Advisor, and the SC Field Office Director met in Kabul with representatives from both MSH/REACH and the USAID Mission to discuss results from the DIP workshop, the CS-19 strategies and approaches, collaboration between SC and MSH on the quality improvement approach, and the reporting format of CS-19 activities to MSH. The results and recommendations from the meetings and DIP workshop have been included into the DIP document, and vetted with a CS-19 Task Force consisting of members from the Provincial Health Coordination Committee with expertise in the technical areas of CS-19. The purpose of the Task Force is two-fold: to review and revise the DIP document, and to

meet periodically and monitor CS-19 activities. Task Force members participating in DIP preparation discussions are listed in the footnotes corresponding to each intervention.

#### **D. REVISIONS FROM THE ORIGINAL APPLICATION**

Given the changes in MOH policy, and the start-up of the REACH program mentioned in the Executive Summary and in Section C, significant revisions to the design and activities of CS-19 have been made from the time of the original application. This section, along with the detailed description of each intervention (Section E.2), outlines these changes.

1. There are no changes with respect to the **program site/location** from the proposed application: CS-19 will cover all of Jawzjan Province, including the Andkhoy “cluster” of four districts: Andkhoy District, Qurghan, Qaramqul, and Khanecharbagh.
2. There are no changes with respect to international training costs. One additional international trip has been added, to allow the Asia Area Health Advisor to attend the DIP Mini-University.
3. SC currently estimates the total **population** of the site to be 707,510 (calculated with a 1.8% population growth rate) compared to the estimate cited in the application of 695,000, including 155,800 women 15 to 49 years old (compared to 153,000 in the original application), and 124,800 children under 5 (compared to 122,000 in the original application.) The current estimate of the total number of beneficiaries is 280,000.
4. The **Results Framework** of the revised project has changed slightly from the original design to reflect provincial level strengthening, the primary strategy of the revised CS-19. Thus, the original Goal 2 (*CS-19 approaches to inform MCH policy/programming beyond Jawzjan*) is no longer part of the new design due to new national BPHS policy that will inform MCH programming, and with subsequent MCH-related policies currently in development. Because the SC CS-19 Coordinator sits on the Executive Committee of the Provincial Health Coordination Committee (see Annex 10 for PHO Terms of Reference), SC and CS-19 will play a significant role in informing new developments in national policy. R-1 in the original design (*Improved health practices at the household level, and increased use of essential MCH services in Jawzjan Province*) has been re-named the Strategic Objective, and R-2 (*Access, quality, and coverage of essential Jawzjan MOH MCH services sustained after SC phase-out*) has been eliminated due to REACH programming investing into the locations SC expected to phase-out. Because REACH will be initiating new activities and introducing new staff into these areas, CS-19 will maintain presence in these areas, and continue to offer provincial level strengthening and technical support for the REACH district and community interventions. Therefore, the Andkhoy cluster, which was planned for early phase-out and subsequent evaluation, will now be on the same timeline of CS-19 activities as the rest of Jawzjan Province. IR-1 (*Increased household-level knowledge of essential MCH practices in Jawzjan*), IR-2 (*Increased access to essential MCH services in Jawzjan*) and IR-3 (*Improved capacity of the Jawzjan MOH to provide quality MCH services*) are the same, with slight re-wording of IR-3 to “*increased quality of essential MCH services.*” The removal of the capacity-building component from the original IR-3 is indicative of the new design, as capacity-building is now the primary cross-cutting strategy for CS-19, and not limited to the quality IR. The original IR-4 (*Innovative approaches to improving essential MCH services tested, documented, and scaled up*) has been moved to the Strategies section, as it is a cross-cutting approach that will be key to the contribution of CS-19 to the BPHS. Finally, Afghanistan is in the tenuous position of trying to rebuild the health system in an environment that, although much improved, continues to experience lawlessness, and intermittent violence

that can slow development efforts. Therefore, CS-19 addresses the fact that a supportive social network or environment is key to establishing improved practices and use of services in its new IR-4: *Established social network to support key behaviors*. Through the strategies of CS-19 and the network of organizations implementing the BPHS, the household level and community level support necessary to adopt key behaviors, along with knowledge, access and quality of services, will result in improved practices and use of services that will ultimately reduce maternal and under-five mortality in Jawzjan.

5. The **interventions** for CS-19 have been adapted from six to five, with the following levels of effort:

▪ **Immunization has decreased from 25% to 20%.**

CS-19 will support many of the same activities indicated in the original proposal, but will concentrate more on technical and logistics management capacity-building of the Provincial Health Office counterparts, responsible for oversight of all EPI activities. CS-19 will no longer include the recruitment of additional female vaccinators as a strategy, as this is part of the REACH program, but will support the MOH and REACH in this effort as needed. Due to the increased focus on EPI initiatives through REACH, CS-19 is lowering the level of effort by 5 percent.

▪ **Nutrition and Micronutrients has changed to Nutrition, and has increased from 5% to 15%.**

Comments from the DIP workshop as well as the CS-19 Application Debriefing Summary suggested a greater emphasis on the nutrition intervention. In the original design, nutritional activities focused on supporting Vitamin A supplementation for 6-59 month olds, and to a lesser degree, supporting efforts to provide ferrous sulfate and folic acid supplements to pregnant women. Due to a heavy emphasis on Vitamin A distribution from a number of national and international NGOs in Jawzjan, as well as a relatively high coverage rate of vitamin A in the KPC baseline study for Jawzjan,<sup>1</sup> CS-19 has dropped the Vitamin A component of this intervention completely (however, Vitamin A administration will be a component of the EPI training), and increased the percentage of effort to concentrate on other, challenging nutritional issues facing children under 5. SC KPC findings indicated that over one-third of mothers were waiting over 24 hours to initiate breastfeeding (many women believe colostrum is harmful to an infant), and about one-third of children measured below the second standard deviation measured in weight-for-age (refer to full report in Annex 2.e.) The changes to the nutrition intervention reflect provincial capacity building for nutritional program design, behavior change messages, and monitoring and evaluation. Additionally, in response to requests from the MOH and the Provincial Health Committee, CS-19 will support iodine fortification by assisting in the development of key messages and behavior change communication, and will work with UNICEF in the logistics management required to deliver the iodized salt from the new factory in Shigerghan town to the shopkeepers, and into homes in all districts of Jawzjan Province.

---

<sup>1</sup> Two-thirds of mothers reported that their child had received a VitA capsule within the previous six months, which is just six percentage points below the target for Vit A coverage (Target #7: 75% of 12-23 month olds received vitamin A in the last 6 months.) The recommendation following the KPC baseline was to consider removing the objective due to the high rate when compared to other challenges related to nutrition like breastfeeding and poor weaning food and diet variety.

▪ **Control of Diarrheal Diseases remains the same at 15%.**

Much of this intervention remains the same, and will support the CDD activities outlined in the IMCI component of the BPHS. CS-19 will concentrate more efforts at the provincial level and will offer additional trainings to key MOH staff and providers at the provincial and district levels. A primary approach remains behavior change communication, monitoring and evaluation, and quality improvement.

▪ **Pneumonia Case Management remains the same at 20%.**

Much of this intervention remains the same, and as with CDD, CS-19 will support the ARI activities in the IMCI component of the BPHS, focusing at the provincial level instead of working with health facility staff and communities directly. CS-19 will work with REACH and the MOH counterparts to provide TOT courses, and will train providers as requested using WHO and UNICEF protocols, as in the original design.

▪ **Maternal and Newborn Care has *increased* from 20% to 30%.**

The DIP workshop identified maternal and newborn care as a priority both in the BPHS and in Jawzjan, and the level of effort in CS-19 was increased to reflect this prioritization. MNC activities will focus on provincial level strengthening, and will be similar to the focus in the original design, with the exception of support and trainings for TBAs. New MOH policy, as of December 2003, has drawn upon the findings of a recent meta-analysis on TBAs<sup>2</sup> and determined that TBAs have had a negative effect on maternal mortality and a marginal effect on perinatal/neonatal mortality.<sup>3</sup> Therefore, the new policy states that all deliveries in Afghanistan should be attended by a skilled provider; i.e. a community midwife, a midwife in a facility, or a doctor, and that no NGO will be providing new TBA training or offering support to existing TBAs. However, existing TBAs will be able to supplement their skill and become CHWs, and CS-19 will be actively involved in further discussion and decision-making on this issue via the Provincial Health Committee monthly meetings. The details of CS-19 midwife training represent a slight change and expansion from the original application, and are discussed in the Strategies section of Section E.2.

▪ **Child Spacing, originally at 15%, has been *eliminated* as a separate intervention, with revised FP activities integrated into the MNC intervention.**

The family planning activities planned through the BPHS, and supported by REACH, include counseling on FP methods, STD screening and treatment, and will offer from two to six different FP options at all facilities. These services will be phased in at a later date than others in the BPHS. This intervention included conducting FGD with community members exploring current attitudes, perceptions and beliefs surrounding FP, and while the MOH is interested in collaborating on this research, discussions and planning will most likely take place mid-project in CS-19. Throughout the five years, CS-19 will provide training and support to the MOH on FP activities, assist in developing strategies to assist families in making informed decisions, offer technical assistance on monitoring and evaluation to ensure quality of care, and assist in the development of IEC materials as requested and in conjunction with initiation of FP activities through the BPHS. These activities are now represented within the MNC intervention of CS-19.

---

<sup>2</sup> Sibley LM, Sipe TA. *Traditional birth attendant training effectiveness: a meta-analysis*. Submitted to Academy for Educational Development SARA Project, 2002.

<sup>3</sup> MOH Policy Statement. *Safe Motherhood Initiative in Afghanistan. Maternal Health Services at the Community Level and Who Should Provide These Services*. 24 December 2003. MOH Transitional Islamic Government of Afghanistan. CS-19 Afghanistan: *Provincial Strengthening*. DIP Draft. Save the Children, April 2004.

6. The **strategies** for CS-19 have been slightly adapted to reflect changes in MOH policies, and to complement MCH activities through REACH. Revisions are indicated here, with further detail discussed in Section E.2. The original Strategy 1 (*Joint SC/MOH program planning, implementation and evaluation; and CHW training, support and supervision*) has been adapted and expanded to reflect the following principle cross-cutting strategy: *Provincial-level strengthening of the MOH in Jawzjan through training, capacity-building of the PHO, and supervision to effectively support the BPHS*. The second strategy in the original design (*Support for pre-service training of midwives, MOH posting of midwives to all MOH BHCs in Jawzjan, integration of midwives into the MOH system, and development of linkages between midwives and TBAs*) has been subsumed into Strategy 1, as midwife training in the new design will represent an element of provincial level strengthening. Details of the midwife training have changed, and are noted in section E.2. Strategy 3 (*Health behavior change activities through health facility staff, CHWs, TBAs, mullahs, teachers, children, and local radio*) remains the same and is now Strategy 2. CS-19 will play an important role in assisting the PHO and the PHCC network of NGOs in the development of BCC materials. Additionally, results of the SC breastfeeding research (see Annex 2.e.) will be used in the development of the BCC strategy. Strategy 4 (*CS-19 engagement with health sector partners to leverage resources in support of essential MCH activities in Jawzjan and to inform emerging national policies and programming*) remains the same, with only minor wording changes. Strategy 5 (*Testing innovative approaches to improving access, quality, and use of essential MCH services; documentation and dissemination of feasibility and results; and scaling-up of successful approaches: Community Defined Quality (CDQ), and Community Case Management (CCM.)*) remains the same as in the original design and is, in fact, considered one of the most valuable contributions that CS-19 brings to the current health planning in Jawzjan.
7. In keeping with the provincial-level strengthening strategy, and in response to the specific request of the Provincial Health Director, CS-19 will join UNICEF and WHO to **support six MOH mobile clinics** in rural areas of Jawzjan that do not fall within REACH funding. This new activity is described in detail in the Strategies section of E.2.
8. One of the four principle criteria for choosing the interventions/activities of the BPHS is the need to ensure that health services are provided to all, especially the poor.<sup>4</sup> Drawing on SC's resources, state of the art research and practical tools for measurement, and SC's historical commitment to **equity**, CS-19 will work with other REACH-funded organizations through the Provincial Health Committee to develop action plans for integrating equity in program design, implementation, monitoring and evaluating.
9. Many of the comments in the CS-19 **application review** have been applied to the new design, and a detailed response is located in Annex 1.
10. In December 2003, the Cooperative Agreement with USAID for CS-19 was adapted to reflect revisions in the **reporting format** from the annual reports required by the CSHGP, to quarterly performance reports including an Output Indicator Table and a Quantitative Data Summary report to be submitted to the USAID Coordination Technical Officer (CTO), the Mission Health Advisor and the REACH Program Coordinator. The external mid-term and final evaluation required by CSHGP would remain the same. The first CS-19 quarterly report was completed in January 2004 and hand-submitted in March to the Mission and REACH representatives, with an electronic copy sent to the USAID CTO. Subsequently, in a meeting on March 15, 2004 with

---

<sup>4</sup> The four selection criteria in the BPHS document (page 8) are the following: "1. Technically effective services that can be delivered successfully in Afghanistan; 2. Targeted diseases are those which have imposed a heavy burden on Afghanistan, considering the effect on the individual with the illness as well as the social impact of the disease; 3. Sustainability of the services in the long-term as donors reduce support in the years ahead, taking into consideration the government's ability to maintain a basic level of health services, and 4. the need for equity in ensuring that critical health services are provided to all, especially the poor."

SC staff (the Child Survival Specialist, the Asia Area Health Advisor, and the SC Field Office Director), the Mission Population, Health and Nutrition Officer and two REACH Program Coordinators, it was decided that the existing quarterly reporting format for REACH-funded organizations was not appropriate for CS-19 and that a format more appropriate to provincial-level activities was under development. As of the writing of this document, this format is not yet available, and SC recommends that the CS-19 Cooperative Agreement be changed to correspond with the CSHGP reporting schedule of annual reports, with copies submitted to the Mission and REACH Program.

## **E. DETAILED IMPLEMENTATION PLAN**

### **1. Summary of Baseline and Other Assessments**

#### **1.1 The CS-19 site and country context, including health status**

Socio-Economic Conditions in Jawzjan: Jawzjan Province in northern Afghanistan borders Turkmenistan to the north and west, Saripul and Faryab provinces to the south, and Balkh province in the east. The province is a flat area, starting from the foot of the Al Burj mountains in the south, stretching out into dessert-like planes in the north. Jawzjan has a border crossing with Turkmenistan in the northwest, through which many trucks with goods from Iran enter the country. Shiberghan is connected with a paved road to Mazar-i Sharif, 1.5 hours to the east, while unpaved roads connect the province to Saripul town and to Maimana in Faryab. All secondary roads connecting the districts within Jawzjan are unpaved. Several districts have easy access to Shiberghan, but several have very difficult access, requiring up to a whole day's travel in a four-wheel drive vehicle.

Part of the province is used for irrigated agriculture, mainly around the two main water sources, the Saripul River and the Balkh River, as well as the Amu River that forms the border between Turkmenistan and Jawzjan. Potable water is collected by people from rivers, irrigation canals, and wells. There is rainfall during the winter months allowing for rain fed agriculture, especially nearer the hills in the south. In most Jawzjan districts, carpet and gillim<sup>5</sup> weaving is an important industry, with carpets exported to Pakistan, Europe, and the US. Another major source of income is natural gas near Shiberghan, which is transported via a pipeline to Mazar-i Sharif. Electricity enters the province in the northwest from Turkmenistan, with Andkhoy District, parts of Qurghan District, and Shiberghan connected to the grid.

The province consists of 14 districts, including the small city of Shiberghan (population 134,000) the provincial capital, the two smaller towns of Aqcha (100,000) and Andkhoy (80,000), and approximately 332 villages. The population is almost 100% Sunni Muslim. The CS-19 baseline KPC Survey, conducted in Jawzjan Province in December 2003, found that 47% of the 300 mothers with children under two years of age belonged to the Uzbek ethnic group, 25% belonged to Turkmen, 14% Tajik, 8% Pashtun, and 7% belonged to other ethnic groups such as Arabs. The KPC survey results revealed that only 13% mothers had ever attended school. The vast majority of mothers (94%) do not work outside the home. The few who do are working in carpet weaving and handicrafts. In Jawzjan, common occupations for men included working in agriculture (60%), salaried workers (15%) or shopkeepers (14%). Nine percent of spouses are reportedly unemployed.

---

<sup>5</sup> Floor coverings that lack the pile of carpets.

This information was not collected in 2003 for the Andkhoy cluster (often considered part of Jawzjan Province), but the KPC survey in 1999 found that Uzbeks represent 63% of the population, while the remaining 33% are Turkmans. Pushtuns, Arabs and Tajik are the minority ethnic groups. Since 1999, the influx of returnees did not affect the Andkhoy cluster, where the population composition remains largely the same. Twenty-one percent of mothers attended some school. The vast majority of mothers in Andkhoy cluster (89%) do not work outside the home. Additional information collected in 1999 showed that in Andkhoy cluster 91% mothers were carpet weavers. In Andkhoy, 52% husbands were daily laborers, 23% were employed as laborers on agriculture farms and 13% were shopkeepers. Twelve percent were unemployed.

There are 179 schools in Jawzjan,<sup>6</sup> enrolling approximately 43,000 girls and 50,000 boys. There is a Turkish-supported primary and secondary school in Shiberghan, and facilities of higher education in Mazar-i Sharif. Literacy rates for the province are unavailable, but rates for all Afghanistan are low,<sup>7</sup> with higher rates in urban centers, such as Shiberghan and Aqcha in Jawzjan, and literacy among men more than twice as high as among women.

Politically, Jawzjan is controlled by the Jumbesh group, with its headquarters in Shiberghan. Although there have been continuing tensions, instability, and small-scale conflicts in some northern areas where more than one group has a presence, Jawzjan has been relatively quiet as only one group is present.<sup>8</sup>

**Health Status:** Population-based estimates for indicators related to health status, practices, and service coverage remain largely unavailable. The 2000 MICS survey only covered eight provinces in eastern Afghanistan, and thus is not representative of the country as a whole, or of the CS-19 site in the north. Estimates of under-five mortality in the country are among the highest in the world, ranging from 257 deaths per 1,000 live births<sup>9</sup> to 279 per 1,000.<sup>10</sup> UNICEF also reports that under-five mortality remained essentially unchanged during the decade from 1990<sup>11</sup> to 2000. Afghanistan is a Profile 1 country,<sup>12</sup> in which pneumonia, diarrhea, and neonatal disorders are the principal causes of under-five deaths, malnutrition contributes as an underlying cause to a large proportion of these deaths, and malaria<sup>13</sup> and AIDS each account for fewer than 10% of deaths. UNICEF reports<sup>14</sup> that 52% of children under five are stunted (< -2Z HFA), 48% underweight (< -2Z WFA), and 25% wasted (< -2Z WFH), that vitamin A supplementation coverage was 84% in 2001, but that only 2% of households consume iodized salt.

---

<sup>6</sup> Ministry of Education data.

<sup>7</sup> According to The State of World's Children 2002, UNICEF, 2001, the adult literacy rate in the country in 2000 was 51% among males and 21% among females.

<sup>8</sup> The Jumbesh group is lead by General Dustum. Since the defeat of the Taliban, General Dustum has been the head of the military forces in the north and shares power with Ustaz Ata, the leader of Jamiaat.

<sup>9</sup> The State of World's Children 2004. UNICEF, 2003. This estimate is based on the 1997 nationwide MICS survey. MICS uses indirect demographic methods to estimate under-five mortality over a period of time several years prior to surveys.

<sup>10</sup> US Bureau of the Census, International Database, 2000 Updates (as cited in the FY-2003 CSHGP RFA). For countries with incomplete vital events reporting, the USBC uses data on reported vital events and an estimate of the extent of under-reporting, to estimate mortality rates.

<sup>11</sup> <5 MR was 260 in 1990 according to The State of World's Children 2002. UNICEF, 2001.

<sup>12</sup> Black RE, Morris SS, Bryce J. Where and why are 10 million children dying every year? Lancet 2003; 361: 2226-34.

<sup>13</sup> In Afghanistan, most malaria is due to *P. vivax*, with about 15% due to *P. falciparum*. Waldman R and Hanif H. The Public Health System in Afghanistan, page 10. Afghanistan Research and Evaluation Unit, May-June 2002.

<sup>14</sup> UNICEF Statistics. Afghanistan. [www.unicef.org/statis/Country\\_1.html](http://www.unicef.org/statis/Country_1.html), and The State of the World's Children 2004.

WHO, UNICEF, and UNFPA have recently published an estimated range of maternal mortality for Afghanistan in 2000 of 470 to 3,500 deaths per 100,000 live births, with a point estimate of 1,900 (based on a regression model prediction that 46% of all deaths in women of reproductive age are due to maternal causes).<sup>15</sup> A recent reproductive age mortality survey in four urban and rural areas of Afghanistan (which may not be representative of the country as a whole) found a maternal mortality ratio of 1,600 (95% confidence interval of 1,100 – 2,000), and 48% of all deaths among women of reproductive age due to maternal causes.<sup>16</sup> Verbal autopsy interviews suggested that hemorrhage was the leading cause of maternal death, followed by obstructed labor. A high total fertility rate, estimated at 6.8,<sup>17</sup> contributes to a very high lifetime risk of death due to pregnancy-related causes, estimated by the UN at approximately 1 in 6.<sup>18</sup> Fertility has declined little since 1960, when it was estimated to be 7.7.<sup>19</sup>

Data on the health status of mothers and children in Jawzjan Province as a whole is not available. However, maternal and child health problems in the Andkhoy cluster of four districts in Jawzjan at the start of SC health activities were likely similar to the current health problems in other districts of the province, where basic MCH services, with the exception of EPI activities, are very limited in rural areas. The initial baseline PRA, jointly conducted by SC and MOPH in 1995, identified pneumonia, diarrhea, measles, neonatal tetanus, and malnutrition as major killers of children under five. The baseline assessments also revealed many maternal deaths due to complications during and after childbirth, many arising from home deliveries assisted by relatives and untrained TBAs with inadequate knowledge of safe birth practices. More recently, a nutrition survey conducted by SC, with a random sample of 881 children under five in the Andkhoy cluster of four districts in June 2002 found 9% of children under five wasted (<-2Z WFH), substantially lower than UNICEF's estimate of 25% for Afghanistan as a whole but within the range of the other recent surveys. Of the children under 30 months of age in Andkhoy, 17% were wasted, while only 4% of 30-59 month olds were wasted. Among the girls in the sample, 6% were wasted, while 11% of the boys were acutely malnourished.

## 1.2 Types and methodology of CS-19 baseline assessments, including sampling techniques and the interview processes

(Note: Training details for all baseline assessments are provided in Section C, #3-Baseline Studies. Once data were entered, a consultant<sup>20</sup> further cleaned and analyzed the data. Findings were shared with the MOH and SC staff to discuss, draw conclusions and develop recommendations. Baseline reports are included in Annexes 2.a., 2.b., 2.c. 2.d. and 2.e.).

---

<sup>15</sup> Maternal Mortality in 2000: Estimates Developed by WHO, UNICEF, UNFPA. ([http://www.who.int/reproductive-health/MNBH/maternal\\_mortality\\_2000/index.html](http://www.who.int/reproductive-health/MNBH/maternal_mortality_2000/index.html)). Because of the lack of both a good vital events registration system and good nation-wide survey-based estimates, this estimate is based on a regression model to predict the proportion maternal among all deaths in women of reproductive age (46% for Afghanistan), and then applying this to “an envelope” of all deaths of women of reproductive age in 1995, obtained from UN population projections. The approach yields a very wide range of uncertainty around the point estimate.

<sup>16</sup> Maternal Mortality in Afghanistan: Magnitude, Causes, Risk Factors and Preventability. Summary Findings. Afghan Ministry of Public Health, US Centers for Disease Control and Prevention, UNICEF, 6 November 2002 (<http://www.unicef.org/media/publications/maternalmortalityafghanistan.doc>). The summary findings document notes that study was conducted in four provinces: Kabul, Laghman, Kandahar and Badakshan, and that these provinces were selected to represent a spectrum of urban to rural development, as an indicator of access to health care providers and facilities, but does not note that this sample is representative of Afghanistan as a whole.

<sup>17</sup> The State of World's Children 2004. UNICEF, 2003. Contraceptive prevalence in Afghanistan is approximately 5%.

<sup>18</sup> Maternal Mortality in 2000: Estimates Developed by WHO, UNICEF, UNFPA.

<sup>19</sup> The State of World's Children 2004. UNICEF, 2003.

<sup>20</sup> Mr. Garth Osborn, MPH.



A. *KPC Surveys*: Two KPC surveys were conducted, one in the Andkhoy cluster of four districts, and a second in Jawzjan, excluding the Andkhoy cluster.

For the Jawzjan survey, the questionnaire was developed based on the KPC 2000+ Manual developed by Child Survival Technical Support at MACRO, the Monitoring and Evaluation Working Group of CORE, and USAID, and the following eleven KPC-related project objectives:

- Twenty percent increase in mothers of children under two receiving two or more TT before birth of youngest child.
- Sixty percent of 12-23 month olds fully immunized against six diseases by age 12 months.
- Eighty percent of 12-23 month olds receive measles vaccine.
- Seventy-five percent of 12-23 month olds received vitamin A in last 6 months.
- Twenty-five percent increase in ill children receiving increased fluids and continued feeding during illness in past two weeks.
- Twenty-five percent increase in mothers reporting hand washing before food preparation and child feeding, and after defecation and child defecation.
- Fifteen percent increase in percent of children under two whose births were attended by skilled health personnel.
- Twenty-five percent increase in mothers with one or more postpartum check.
- Five percent increase in non-pregnant mothers who desire no more children in next two years, or are unsure, who are using a modern method of child spacing.
- Sixty percent of mothers know two or more signs of child illness needing treatment.
- Twenty percent increase in mothers with knowledge of at least two maternal danger signs during the postpartum period.

The questionnaire included 75 questions and covered all of the CATCH indicators and relevant portions of the KPC modules for:

**Table 2. Jawzjan KPC Survey Questions**

Component	KPC Question Numbers
Demographics	1—12
Maternal Health Care	13 – 37
Antenatal Care	13 –24
Delivery/Immediate Newborn Care	25 – 29
Postpartum Period	30 – 37
Breastfeeding and Infant/Child Nutrition	38 – 43
Immunization	44 – 48
Care of the Sick Child	49 –52
Diarrhea	53 – 60
Acute Respiratory Infections	61 – 64
Child Spacing	65 – 68
HIV/AIDS	69 – 70
Malaria	71 – 73
Health Education	74 – 75

The questionnaire was translated from English into Dari and field tested in Sheberghan City on November 13, 2003. Based on the results of this test, minor changes were made in the content and formatting of the questionnaire for use in the field.

The 30-cluster sampling method was used to select communities where the interviews would take place based on a list of all the communities and the estimated population of each, acquired from Save the Children, the Jawzjan MOH, and the government Central Statistics Office. Ten mothers of children under the age of two were interviewed in each cluster for a total sample of 300 mothers.

Mothers were interviewed at home. The project used the following process for selecting the first household and subsequent households in each cluster:

1. Start from a central point within the community.
2. Spin a bottle to select a direction.
3. Count the number of households in the selected direction from the center of the community to its border.
4. Randomly select a number that falls within the range of the total number of households counted.
5. Count out from the center of the community the randomly selected number of households starting from the first house. This is the first house visited.
6. If there is no mother of a child below the age of two years, then the interviewers would keep going to the next nearest household until they interviewed ten mothers.

Four supervisors and 20 interviewers were used to collect the data. The supervisors were all Save the Children staff and the interviewers were recruited from SC's community volunteers, MOH nurses, and school teachers. All were required to be literate and have a basic understanding of maternal child health. The training of the interviewers and supervisors was done from November 10-12, 2003 by Dr. Tariq Ihsan, Dr. Honey, Dr. Rahila, and Mr. Homaira. Data collection was done from November 14 – 21, 2003. The primary challenges were from the cold and rainy weather as well as the difficulties in reaching some of the farther communities within the project area. Data entry into EPI INFO 6.04 took nine days starting on November 15 and involved three individuals. The data files were then sent to the U.S., where they were cleaned. Then the results were printed out and sent back to the field for discussions between SC and partnering MOH staffs.

#### *B. Health Facility Assessments:*

The project used the four Integrated Health Facility Assessment (IHFA) questionnaires developed by USAID/BASICS (1. Observation Checklist – Sick Child, 2. Exit Interview – Sick Child, 3. Health Care Worker Interview, and 4. Equipment and Supplies Checklist) to evaluate:

- The assessment, diagnosis, and treatment of children with diarrhea, fever and malaria, and ARI;
- The screening and vaccination of women and children against common vaccine-preventable diseases;
- How well caretakers provide home treatment for their children;
- How well health workers educate caretakers about preventive and curative care;
- The quality of training and supervision received by health workers; and
- Equipment, supplies and record keeping in health facilities.

The assessment team adapted these questionnaires slightly to more accurately reflect the situation, better understand the availability and use of family planning methods, and measure baseline rates for the following IHFA-related project objectives:

- Eighty percent of severely ill under-fives will be classified correctly in CS-19-supported facilities.
- Eighty percent of under-five pneumonia cases will be treated correctly in CS-19-supported facilities.
- Eighty percent of under-five diarrhea cases will be treated correctly in CS-19-supported facilities.
- Sixty percent of caretakers of under-fives receiving oral drugs will know how to administer all essential drugs at home.
- Sixty percent of caretakers of under-fives will know at least two aspects of home care.
- Sixty percent of caretakers of under-fives will know at least two signs of when to return if child gets worse.
- Ten percent of CS-19 supported facilities will have had one or more stock-outs of ORS or essential drugs last month.
- Ninety percent of CS-19-supported facilities will achieve perfect EPI quality index score.
- One hundred percent of BHCs will have FP-trained female health worker posted and three birth spacing methods in stock.

The assessment team included seven doctors from Save the Children and seven nurses from the MOH. The doctors were responsible for implementing the observation checklist, the health worker interviews, and the supply/equipment checklists. The nurses implemented the exit interviews with caregivers. The doctors and nurses received two days of training from Dr. Tariq Ihsan and other senior Save the Children health staff on December 4-5, 2003. The questionnaires were translated from English into Dari and field tested in Andkhoy on December 6, 2003. (Questionnaires are included in the Baseline Reports in Annex 2.)

The assessment team visited a total of fourteen health facilities in the project area, including eight BHCs, two district hospitals, one CHC, one MCH clinic, one health post, and the pediatric department of the provincial hospital. This constituted all of the health facilities in the area except for two: one that was deselected because of its location near the airport and the lack of villages within its catchment area, and the other because it does not provide curative services to children under five. The visits to these facilities were made unannounced to provide as accurate a picture as possible of their regular services.

While at the health facilities, 13 physicians and one nurse were interviewed using the Health Worker Interview questionnaire; the supplies and equipment were inventoried; and 109 examinations of children under the age of five were observed, the diagnosis they received from the health workers were validated, and their caretakers were interviewed. The project attempted to reach the suggested sample size of ten observations and interviews per facility. However, two of the facilities only had three sick children come for care over a two and a half day period. The data was entered into EPI INFO version 6.04 by four individuals from December 8 – 11, 2004 and sent to the U.S. for cleaning. The findings were then written out and sent back to the field for discussions and review, in preparation for developing the project's DIP. In addition to the limited number of patients and caretakers available for observation and interviews at two of the facilities, the other challenges

were the cold and rainy weather as well as the distances to the more distant facilities, which delayed the data entry. Results of the HFA were tabulated separately for Jawzjan Province and for Andkhoy cluster, due to the presence of SC activities already in Andkhoy.

### *C. Participatory Rapid Appraisal on Community Knowledge, Practices, and Beliefs about Maternal and Newborn Care:*

As discussed in Section C #3, the KPC findings indicated the need for more qualitative research into barriers to health seeking, particularly immunization and safe motherhood services. Three checklists were developed to target different community members and to elicit information around key issues mentioned above. A two-day refresher training was given to six female and four male trained schoolteachers and health workers in Andkhoy cluster, and a three-day training on PRA techniques was given to six female schoolteachers and nurses and four male health workers in Jawzjan. The focus group discussion exercises were carried out for a period of four days with support from SC and MOH senior health staff. A total of 288 community members participated in 32 focus group discussions in Andkhoy and Jawzjan. Participants mainly included mothers with children less than six months old; mothers and fathers with children 6-24 months old; and women and men who participated in family planning discussions. Data coding and analysis is underway and a final report is expected by May 2004.

### *D. Gap Analysis – Maternal and Newborn care*

The Gap Analysis Tool (GAT) is an assessment tool that has been developed by Save the Children to learn more about the content and comprehensiveness of safe motherhood and newborn programs. It is intended to serve as the initial assessment tool to evaluate the status and content of SM/NB programs before decisions are made in the direction the program should take. This will help programs use resources profitably where and when needed.

The GAT assesses activities at the household/community level, peripheral and district level capacity, while linking all the three levels. This initial assessment is based on best practices and evidence-based efforts that have been shown to improve and protect maternal and newborn survival and covers the areas of community education and mobilization, pregnancy, labor, delivery and the postpartum period. In addition, it looks at quality improvement methodologies and takes into account the enabling environment for provision of quality maternal and newborn services. It goes further to identify which of the best practices activities are a part of the current SM/NB project, where there are gaps in programming and what more needs to be done to improve the project to promote maternal and newborn survival.

Using the household and community level as an example, the first column of the GAT (Please see Annex 2.g.) is that column that lists all the known best practices. The second column reads: "What is the current practice" (or "What is the project's current activity"), and this question focuses on what is being done NOT what the project planned to do. These are 2 different things and so one may need to get information not only from project people but from the beneficiaries through interviews and focus groups. The next column is the "GAP" and is self-explanatory. This is the missing piece in the program that can add value to the rest of program activities and that will contribute to improve the health outcomes of women and their newborns. It can also be that part of originally planned activities that has not taken place. The final column then asks, "What more could be done (and if done effectively) would improve maternal and newborn survival at the household

and community level?” One then writes what one will do to fill the GAP and this part takes the form of an action statement: who will do what, when, and by what means.

To facilitate monitoring and evaluation, most of the “best practice” activities in the GAT have either a process or quality indicator to monitor progress and facilitate ongoing evaluation and improvement of the activity.

### 1.3 Summary findings of baseline assessments

**Table 3. Indicators, Methods, Baseline Values and Corresponding Intervention for the Andkhoy Cluster**

Strategic Objective/ Intermediate Result	#	Indicator	Method	Baseline value	Interv
<b>SO:</b> Improved health practices at household level, & increased use of essential MCH services, in Jawzjan Province.	1	Percent of mothers who received at least two TT injections (card-confirmed) before the birth of the youngest child less than 24 months of age.	KPC Survey	79%	MNC
	2	Percent of children aged 12-23 months who received BCG, DPT3, OPV3, and measles vaccines before the first birthday (by card.)	KPC	64%	EPI
	3	Percent of infants who received DPT-3.	HIS	24%	EPI
	4	Percent of children aged 12-23 months who received measles vaccine (by recall.)	KPC	72%	EPI
	5	Percent of children aged 0-23 months with illness in the last two weeks were offered more fluids during the illness.	KPC	20%	CDD ARI
	6	Percent of children aged 0-23 months with illness in the last two weeks were offered the same or more food during the illness.	KPC	27%	CDD ARI
	7	Percent of mothers who usually wash their hands with soap or ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated.	KPC	69%	CDD
	8	Percent of children aged 0-23 months with cough and fast/difficult breathing in the last two weeks were taken to a health facility or received antibiotics from an alternative source	KPC	84%	ARI
	9	Percent of children aged 0-23 months whose delivery was attended by skilled health personnel.	KPC	13%	MNC
	10	Percent of mothers who had at least one postpartum check.	KPC	82%	MNC
	11	Percent of infants aged 0-5 months that were fed breast milk only in the last 24 hours.	KPC	66%	Nut
	12	Percent of infants aged 6-9 months who received breast milk and solid foods in the last 24 hours.	KPC	Not available	Nut

<b>IR-1:</b> Increased household-level <b>knowledge</b> of essential MCH practices in Jawzjan.	13	Percent of mothers able to report at least two known maternal danger signs during the postpartum period.	KPC	70%	MNC
	14	Percent of mothers of children aged 0-23 months who know at least 2 signs of childhood illness that indicate the need for treatment.	KPC	69%	ARI CDD
<b>IR-2:</b> Increased <b>access</b> to essential MCH services in Jawzjan.	15	Percent of MOH facilities with female health workers.	CS-19 records	75%	MNC
	16	Percent of MOH facilities with 1 or more stock-out of ORS or essential drugs last month (HFA #28).	HFA & Superv	100%	CDD ARI
	17	CCM successfully piloted, feasibility documented, and quality & use of CHW CCM services documented.	Final Eval.	No	CDD ARI
<b>IR-3:</b> Increased <b>quality</b> of essential MCH services in Jawzjan.	18	Percent of caretakers of <5's receiving oral drugs know how to administer all essential drugs at home (BASICS HFA indicator #25).	HFA & Superv	67%	CDD ARI
	19	Percent of caretakers of <5's know at least 2 aspects of home care (HFA #26.)	HFA & Superv	87%	CDD ARI
	20	Percent of caretakers of <5's know at least 2 signs of when to return if child gets worse (HFA #27.)	HFA & Superv	96%	CDD ARI
	21	Percent of severely ill <5's classified correctly in MOH facilities (HFA #14)	HFA	50%	CDD ARI
	22	CDQ successfully piloted, feasibility and change in service use documented, community perceptions used by facilities to improve quality.	Final Eval.	No	All
	23	Percent of <5 ARI cases treated correctly in MOH facilities (clinical validation during survey.)	HFA	50%	ARI
	24	Percent of <5 diarrhea cases treated correctly in MOH facilities (clinical validation during survey).	HFA	60%	CDD

**Table 4. Indicators, Methods, Baseline Values and Corresponding Intervention for Jawzjan Province**

<b>Strategic Objective/ Intermediate Result</b>	<b>#</b>	<b>Indicator</b>	<b>Method</b>	<b>Baseline value</b>	<b>Interv</b>
<b>SO:</b> Improved health practices at household level, & increased use of essential MCH services, in Jawzjan Province.	1	Percent of mothers who received at least two TT injections (card-confirmed) before the birth of the youngest child less than 24 months of age.	KPC Survey	15%	MNC
	2	Percent of children aged 12-23 months who received BCG, DPT3, OPV3, and measles vaccines before the first birthday (by card.)	KPC	4%	EPI
	3	Percent of infants who received DPT-3.	HIS	11%	EPI
	4	Percent of children aged 12-23 months who received measles vaccine (by recall.)	KPC	12%	EPI
	5	Percent of children aged 0-23 months with illness in the last two weeks were offered more fluids during the illness.	KPC	23%	CDD ARI
	6	Percent of children aged 0-23 months with illness in the last two weeks were offered the same or more food during the illness.	KPC	26%	CDD ARI
	7	Percent of mothers who usually wash their hands with soap or ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated.	KPC	17%	CDD
	8	Percent of children aged 0-23 months with cough and fast/difficult breathing in the last two weeks were taken to a health facility or received antibiotics from an alternative source	KPC	39%	ARI
	9	Percent of children aged 0-23 months whose delivery was attended by skilled health personnel.	KPC	28%	MNC
	10	Percent of mothers who had at least one postpartum check.	KPC	29%	MNC
	11	Percent of infants aged 0-5 months that were fed breast milk only in the last 24 hours.	KPC	68%	Nut
	12	Percent of infants aged 6-9 months who received breast milk and solid foods in the last 24 hours.	KPC	33%	Nut

<b>IR-1:</b> Increased household-level <b>knowledge</b> of essential MCH practices in Jawzjan.	13	Percent of mothers able to report at least two known maternal danger signs during the postpartum period.	KPC	29%	MNC
	14	Percent of mothers of children aged 0-23 months who know at least 2 signs of childhood illness that indicate the need for treatment.	KPC	14%	ARI CDD
<b>IR-2:</b> Increased <b>access</b> to essential MCH services in Jawzjan.	15	Percent of MOH facilities with female health workers.	CS-19 records	43%	MNC
	16	Percent of MOH facilities with 1 or more stock-out of ORS or essential drugs last month (HFA #28).	HFA & Superv.	Not available	CDD ARI
	17	CCM successfully piloted, feasibility documented, and quality & use of CHW CCM services documented.	Final Eval.	No	CDD ARI
<b>IR-3:</b> Increased <b>quality</b> of essential MCH services in Jawzjan.	18	Percent of caretakers of <5's receiving oral drugs know how to administer all essential drugs at home (BASICS HFA indicator #25).	HFA & Superv.	26%	CDD ARI
	19	Percent of caretakers of <5's know at least 2 aspects of home care (HFA #26.)	HFA & Superv.	59%	CDD ARI
	20	Percent of caretakers of <5's know at least 2 signs of when to return if child gets worse (HFA #27.)	HFA & Superv.	66%	CDD ARI
	21	Percent of severely ill <5's classified correctly in MOH facilities (HFA #14)	HFA	0%	CDD ARI
	22	CDQ successfully piloted, feasibility and change in service use documented, community perceptions used by facilities to improve quality.	Final Eval.	No	All
	23	Percent of <5 ARI cases treated correctly in MOH facilities (clinical validation during survey.)	HFA	30%	ARI
	24	Percent of <5 diarrhea cases treated correctly in MOH facilities (clinical validation during survey.)	HFA	35%	CDD

<b>IR-4:</b> Established <b>social network</b> to support key behaviors.	25	Percent of mothers receiving general information or advice on health or nutrition from a member of the informal community network. <sup>21</sup>	KPC	1%	ALL
	26	Percent of CDQ Quality Improvement Committees including at least one female participant.	Final Eval.	N/A	All

<sup>21</sup> From KPC+2000, the informal network consists of the following: husband/partner, mother/mother-in-law, sister, grandparent, aunt, friend/neighbor, traditional healer, village elder, or other.  
CS-19 Afghanistan: *Provincial Strengthening*. DIP Draft. Save the Children, April 2004.



## **Jawzjan KPC**

**Immunization:** Immunization coverage for children is very low; the DPT dropout rate is high; and less than one fourth of caregivers had EPI cards for their children. In meetings with the MOH to discuss the KPC results, the following reasons for the low immunization coverage were mentioned:

- More emphasis has been placed on the polio eradication campaigns, which have reduced efforts to improve routine immunization at health facilities.
- There is a lack of female vaccinators in the clinics because the female literacy rates in the rural areas are very low, making it difficult to recruit and train qualified candidates into these positions. The low salary rate for vaccinators is also a factor.
- Opportunities are being lost because health workers are not screening women for their immunization status or asking them for their EPI cards when they come to health facilities.
- Vaccinators are receiving little or no useful feedback due to the poor quality of monitoring and supervision.
- Very little is being done in outreach activities and health education. Few of the health facilities have female health educators.
- There is a lack of awareness in the general population about the importance and timing of immunization.

**Maternal and Newborn Care:** Very few mothers had an ANC or TT immunization card, and while roughly two thirds of them had seen a health worker during their pregnancy, fewer than a fourth could remember or document by card having received a TT vaccination. Nearly two thirds of women ate less during their pregnancies even though most were aware of at least some foods that prevent anemia and only about one fifth of pregnant women received iron supplements. The vast majority of children are being delivered in homes assisted by unskilled individuals. Just under one third of mothers had their health checked following the delivery. Even for the mothers attending PPC, very few were receiving health education for themselves or their newborns.

The MOH identified the following reasons for the high number of births that were not attended by trained health workers, the low level of maternal knowledge on postpartum danger signs, and the reasons why so few mothers were going to at least one postpartum checkup:

- Most of the clinics lack basic MCH services and there is no client counseling or education provided so women are not developing birth-planning strategies for their deliveries.
- There is a lack of trained TBAs throughout much of the project area.
- The salary rates for female health workers are low so there is little or no incentive for women to come from outside the district to the project area to work in MOH facilities.
- Many women are going to untrained drug vendors where they can purchase uterotonics, antibiotics, and analgesics. With these drugs, they no longer feel it is necessary to go to the clinic for the delivery or for a postpartum checkup.
- The distance to the nearest health facility is prohibitive for many women.

### **Care of the Sick Child, Including Control of Diarrhea and Pneumonia Case Management:**

Only about one fourth of mothers knew the diarrhea danger signs that would necessitate care or treatment, while knowledge of fast/difficult breathing and fever was better at 58% and 74%, respectively. Of concern, only about a quarter of mothers said that they gave their child more fluids when the child was sick and the same number said they provided the same amount or more feedings. Specific to the control of diarrhea, less than one fifth of mothers knew the four times that

they should wash their hands and fewer than half were able to demonstrate the correct procedure for preparing oral rehydration solution. The most common forms of home-based case management for diarrhea were pills/syrup and injections, with only a fourth of mothers saying they provided ORS. The care and counseling received at health facilities is troubling, with many health workers providing antidiarrheals, some counseling mothers to restrict their child's diet, and only about a third of MOH workers promoting use of ORS. The delay in seeking care and treatment was the primary concern regarding ARI, with 85% of mothers waiting a day or longer.

In talking with the MOH staff about child health-related preventive, home care measures, and danger signs, the following factors were raised:

- Most health workers have not received training on patient counseling, so few are equipped to actively engage the caregivers in a dialog when they bring their sick children to the health facilities.
- No health education or community awareness campaigns have taken place in the rural areas.
- There is a lack of outreach health education, CHWs, health education materials in the local languages, and mass media in most districts.
- There is a lack of female health educators in most clinics.
- There is a low literacy rate and lack of awareness about health in the communities.

***Child Spacing:*** The most popular form of family planning is LAM, and only one sixth of the mothers who were not pregnant and did not want another child were using an alternative modern FP method. Nearly two thirds of the mothers surveyed said they did not know where they could get family planning supplies. MOH representatives noted the lack of family planning programs in most clinics, the lack of awareness about methods, and the fact that women are not the decision makers in the family as the main reasons for the very limited use of modern FP methods. It is not clear from the KPC results whether the low rates of use of modern FP methods are the result of insufficient supply, lack of knowledge on their availability/efficacy, or a lack of interest due to cultural, religious, or other factors. A better understanding of these issues is critical to the design of the project's health education components.

***Nutrition and Vitamin A supplementation:*** Two thirds of mothers reported that their child had received a VitA capsule within the previous six months. While the overall rates for breastfeeding were very positive, about one third of mothers were waiting over 24 hours to initiate breastfeeding. Some mothers have stopped breastfeeding due to the mistaken belief that their breast milk goes bad when they are pregnant. About one third of children measured weight-for-age fell under the second standard deviation – an indicator of childhood malnutrition.

### **Andkhoy KPC**

As a result of the SC, MOH and UNICEF partnership, the EPI program in the Andkhoy cluster has shown success since 1999. Ninety-six percent mothers presented EPI cards as opposed to only 69% in 1999, fewer cards were lost (1.5%) compared to 1999 (18%) and 64% of children are fully immunized children. Additionally, 79% of pregnant women had at least two TT vaccinations compared to 45% in 1999. With regard to maternal and newborn care, most mothers (87%) had antenatal cards, 69% had attended antenatal care at least three times, and 71% had received iron tablets. The proportion of mothers eating more than usual increased from 19% in 1999 to 33% in 2003, and mothers are more aware of danger signs. Despite several achievements, there are areas requiring major improvements such as: increasing access to skilled birth attendants, enhancing efforts to provide postpartum care and education on nutrition.

## **Jawzjan HFA**

***Assessment of the Sick Child by Health Workers:*** The initial screening of children brought to health facilities appears to be very inconsistent, with few assessed for malnutrition, having their temperature taken, having their immunization records checked, or having a basic history taken. While the survey does not address the underlying reasons for this directly, it provides some possible answers. It appears that most of the necessary equipment and infrastructure is available at the health facilities for accomplishing these initial assessment tasks. Health worker knowledge could be a significant factor, based on low levels of knowledge of childhood and maternal immunization schedules and referral signs as well as incorrect diagnosis. Nearly half of the health workers interviewed said that the lack of training was a major challenge they faced in their jobs. Moreover, while supervision appears to be happening at most of the facilities visited, only about one fourth of the health workers report that they are being updated on current information. An additional factor could also be low motivation, which is difficult to measure in this type of a survey but can be explored through focus group discussions (FGD) with clinic staff.

***Educating caregivers on health:*** Important opportunities to provide health education are not being taken at health facilities. Only limited health education is being provided during examinations of sick children, especially in educating caregivers about the correct dosage of medicines, family planning, and danger signs. One reason could be the length of the examinations – averaging 8.2 minutes each – leaving little time to complete the assessment tasks, diagnose, and provide effective health education. Health education during examination might also be considered a low priority for health workers as it is not being covered in supervision and in general, health workers do not seem to perceive many barriers to communicating with caregivers, which could also be read as a lack of interest. Health education also does not appear to be discussed as part of supervision and a majority of the facilities lack health education materials in the local languages, which together communicate the message that health education is not a priority in patient care.

***Care Seeking Behavior:*** Use of BHCs appears to be very low within the project area. Moreover, the length of time between the recognition of danger signs and when a child is brought to a health facility in most situations ranges between two to five days. This is especially critical for pneumonia, where time is of the essence.

***Immunization:*** Vaccines and EPI cards appear to be readily available at the health facilities. However, very few caregivers have cards or report having received them. In addition to the reasons for the low EPI coverage that are listed by the MOH in the KPC report, health worker knowledge of the immunization schedule is very weak and EPI cards for WRA and children are not being checked when they come to health facilities.

***Family Planning Methods:*** Half of the health facilities have supplies of condoms and some have pills and injectables. Half of the facilities have at least one female health worker who has received training in family planning methods. Both the KPC and the IHFA found that LAM is the most

popular form of family planning. Use of other modern family planning methods is reportedly very low, with no one reporting using condoms.

## **Andkhoy HFA**

***Assessment, Diagnosis, and Treatment of the Sick Child by Health Workers:*** Significant improvement was found in the 2003 assessment done of sick children at health facilities. None of

the children had all four assessment tasks completed in 1999 (asking the child's age, weighing the child, plotting child's weight on a growth chart, and checking the child's temperature). This increased to 41% (19/46) in 2003. The MOH credited improved monitoring and regular feedback after monitoring visits as factors contributing to this improvement. The Government is currently field-testing guidelines, which once finalized and put into practice, should help to improve the initial assessments as well as health care overall for children at MOH facilities. Two other factors might be having an impact on these rates: one of the four health facilities surveyed did not have a functioning thermometer to record the child's temperature and plotting the child's weight on growth monitoring cards is not the responsibility of the medical officers, so this might have been underreported.

The assessment of immunization status of both children and women improved significantly, with all of the health workers checking all of the children's cards and 84% (36/43) of the female caregivers' cards being checked. This represents a significant increase from 6% in 1999 to 84% in 2003. The MOH and SC credited the annual EPI refresher courses for this success.

The number of assessment tasks completed by health workers specific to diarrhea, fever, and ARI remained relatively low. For instance, while the number of health workers who completed all of the ARI-related tasks doubled from the 1999 rate of 20%, it was still only 41%. MOH and SC said that the primary reason more health workers were not completing all four ARI tasks was due to the lack of consistent feedback or refresher training since 2001, especially for medical officers. In addition, only one of the four health facilities surveyed had a working timer for counting breaths, which would have further limited these assessments. By contrast, assessment of nutritional status showed positive improvement on all three related assessment tasks:

**Table 5. Nutritional Status Assessment**

<b>Nutrition Assessment Tasks Completed</b>	<b>1999</b>	<b>2003</b>
Both Feet Checked for Edema	23%	76% (35/46)
Undressed and checked for wasting	31%	65% (30/46)
Checked for palmer or conjunctive pallor	29%	59% (27/46)

MOH and SC stated that the continuous training on nutritional assessment, provided through Save the Children's Food Distribution and Nutritional Surveillance Program, was a major factor here.

The survey validators agreed with the medical officers in just over two-thirds of their diagnosis in the 2003 survey.<sup>22</sup> While the rates of agreement were highest on diarrheal diseases, dysentery, and pneumonia, the rates for more common, less severe respiratory and ear infections were not as strong, with both colds and acute ear infections being miss-diagnosed about half of the time. Agreement between the survey validators and the health workers on the medications prescribed and the treatment provided shows that room remains for improvement, especially with regard to pneumonia case management.

***Educating Caregivers on Health:*** The survey, along with anecdotal reports, found improvements in health worker counseling of caregivers from 1999 to 2003. This was attributed to the trainings and refresher trainings on communication skills and caretaker counseling, which were initiated by the project in 2000.

<sup>22</sup> Validators were not available to review and assess the accuracy of the diagnosis done in 1999, therefore, comparison over time cannot be provided here.

**Table 6. Caregiver Counseling Received**

<b>Counseling of Caregivers by Health Workers</b>	<b>1999</b>	<b>2003</b>
Explained how to administer medicines/ORS.	86%	85% (39/46)
Demonstrated how to administer medicines/ORS.	29%	54% (25/46)
Verified caregiver understanding medicine/ORS administration through open questions.	6%	52% (24/56)
Percent of health workers who did 3 tasks above.	6%	35% (16/46)
Explained when to return for follow-up.	75%	80% (37/46)
Told caregivers the child should be given more liquids at home.	32%	59% (27/46)
Told caregivers to continue to feed and/or breastfeed at home.	60%	78% (36/46)

**Family Planning:** In addition to child health, the project added a brief family planning component to the 2003 version of the IHFA survey questionnaire. Just over half of the adult caregivers received counseling on family planning from the health worker and the use of modern family planning methods is very limited. Family planning is still considered ‘low profile’ due to the lack of MOH staff training on family planning, educational materials, and family planning content incorporated into community based health education messages. Of promise, family planning supplies are now being provided through UNICEF.

**Care Seeking Behavior:** Caregivers are taking sick children to health facilities sooner than in 1999, with nearly twice as many seeking care the same day symptoms become apparent and fewer are waiting three or more days to seek care. These positive changes were the result of health education provided by female staff in the clinics, health education provided by both female and male outreach workers in the field, and the project’s ARI and CDD campaigns.

**Home Care:** Twice as many caregivers now know how to administer the essential medicines, increasing from 32% in 1999 to 67% (24/36) in 2003. However, knowledge of the preparation of ORS has declined by a third during the same period. Caregiver knowledge of the common aspects of homecare has improved or remained high in continued feeding/breastfeeding and giving fluids. Overall, 96% (44/46) of caregivers knew at least two or more signs showing that the child needs to return to the health facility, which was a significant improvement over the 1999 rate of 68%. Some topics that require further promotion include knowing to bring the sick child back to the health facility when s/he gets worse and the importance of completing the entire dose of medicines, which decreased significantly from 52% to 31% (14/45).

### **Gap Analysis**

Preliminary findings related to the household and community level suggest:

1. At the household level it is important that the mother and the decision makers know the danger signs and when to seek care. The KPC survey 2003 showed that mothers had adequate knowledge (67% know 2 or more danger signs). No information is available on how much decision makers

such as mothers-in-law and husbands know about danger signs during pregnancy, delivery or postpartum.

2. Health education seldom targets men/husbands because male outreach workers have not received training on birth planning and MOH has no concrete plans to target male decision makers, who have major influence on maternal nutrition and care during pregnancy, with health education.

3. Health education materials on maternal nutrition are inadequate. Health educators and CHWs do not use any materials during health education at the community/ household level. Appropriate BCC strategies and education materials must be developed to address maternal nutrition issues. BCC materials regarding TT vaccines must be developed to address reasons for not seeking TT vaccine. Include messages on Iodized salt as well.

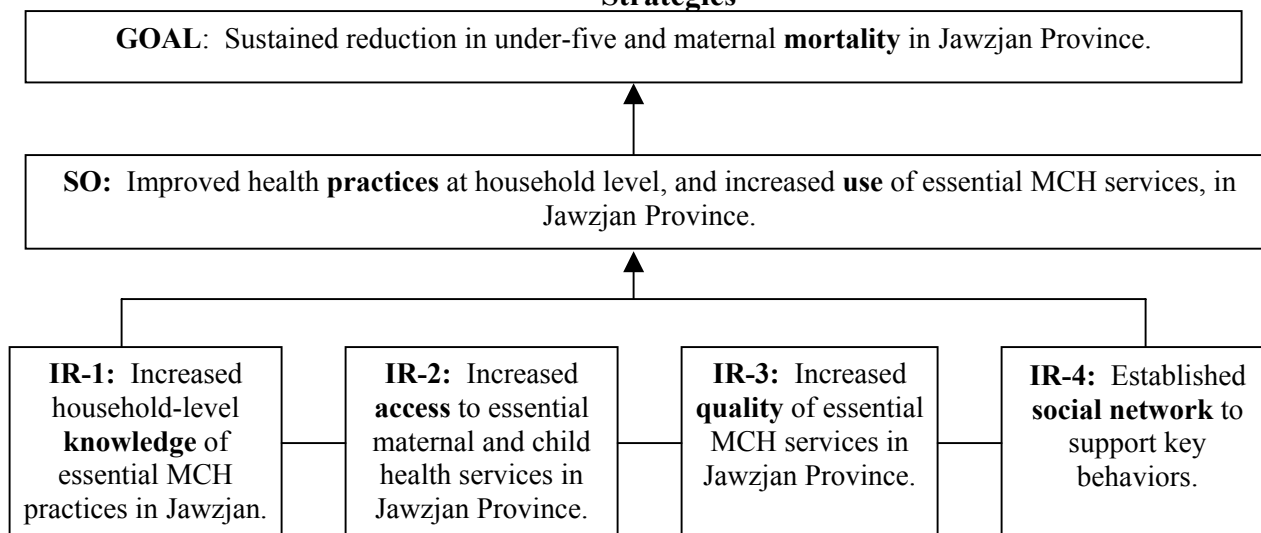
4. There are no health education materials or checklists to refer to for postnatal visits - materials that are important to help CHWs perform good quality postnatal care. Responses on how postnatal care is provided varied from one CHW to another indicating lack of a standard approach.

5. The KPC survey indicated that majority of mothers deliver at home and are assisted by TBAs and relatives. Skilled birth attendants assist few. The gap analysis showed that there is lack of information on the quality of care TBAs provide to mothers. Very few cases have been registered in the peripheral facilities. Group discussions about women who died indicated a lack of birth planning among families - much time was wasted looking for transport.

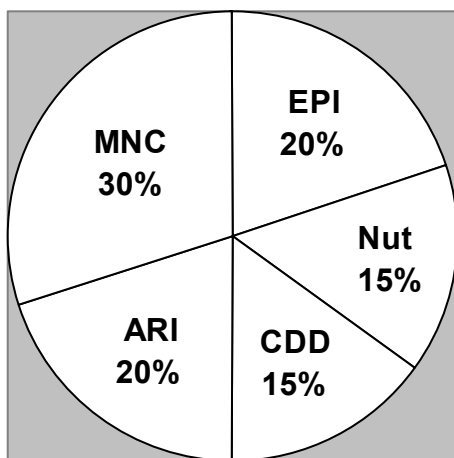
6. There are remote villages where pregnant women do not have access to safe motherhood services and there are no strategies in place to increase access to ANC, including TT and iron tablets, in these areas.

7. Iodized salt is seldom present in the area. Andkhoy is a known iodine deficiency area as many clients with visible/palpable goiter attend clinics. There is no strategy to address this issue of iodine deficiency. ( Please see the Gap Analysis Tool in Annex 2.g.).

**Table 7. CS-19 Goal, Strategic Objective, Intermediate Results, Interventions, and Major Strategies**



**Figure 1. CS-19 Intervention Areas, CS-19 strategies for provincial level support will focus on the following intervention areas, with indicated levels of effort:**



1. Maternal and Newborn Care (MNC)
2. Immunization (EPI)
3. Nutrition (Nut)
4. Control of Diarrheal Disease (CDD)
5. Pneumonia Case Management (ARI)

These interventions will be implemented through the following four major CS-19 cross-cutting strategies:

1. **Provincial-level strengthening** of the MOH in Jawzjan through training, capacity-building of the PHO, program learning, and supervision to effectively support the BPHS;
2. **Health behavior change activities** through health facility staff, CHWs, *mullahs*, teachers, midwives, mother-in-laws, and local radio;
3. CS-19 engagement with health sector partners to **leverage resources** in support of essential MCH activities in Jawzjan; and
4. **Testing innovative approaches** to improving *equitable* access, quality, and use of essential MCH services, documentation and dissemination of feasibility and results, and scaling-up of successful approaches:
  - **Community Defined Quality (CDQ):** Working with community members and health staff to understand and improve the quality of MCH services from the community perspective and increase use of these services; and
  - **Community Case Management (CCM):** Increasing community access to and prompt use of life-saving treatment for childhood diarrhea and pneumonia by training and supporting CHWs to provide this service in areas with poor access.

## 2. Program Description by Objective, Intervention and Activities

### A. Immunization

CS-19 will support the MOH implementation of routine vaccination, TT campaigns, catch-up immunizations, and education. The BPHS activities implemented through the REACH program include plans for EPI services at all four facility levels that will be implemented at the *community and district levels*. These services include: IEC, vaccine storage, routine EPI, outreach immunization, campaigns (NIDs), disease surveillance and case reporting, routine reporting, supervision and monitoring<sup>23</sup>. CS-19 will support these activities through the following training and support at the *provincial level* to the PHO:

#### 1. HMIS technical training

CS-19 will offer technical training and support to the PHO HMIS officer, and HMIS staff at the district level to support EPI services, management and reporting through BPHS structures. Some elements of the HMIS training will include reviewing the standard reporting formats, surveillance, and data analysis. Training guidelines from the MOH national HMIS training module will be used.

#### 2. EPI management and vaccination training for CHWs and vaccinators

Currently, approximately 50% of all vaccinators are untrained.<sup>24</sup> Recruitment of female CHWs and staff is a priority through REACH, and CS-19 will support this strategy through offering training to new female vaccinators and developing plans to improve the quality of immunization services. The CS-19 SC EPI officer, with the help of the MOH EPI officer and the WHO EPI staff in Shibergan will use UNICEF and WHO national guidelines for quality training and EPI programming. CS-19 will aid the MOH and UNICEF in developing micro-plans for immunization in poor access areas through fixed centers, ‘catch-up’ strategies for EPI, and TT campaigns in 2004, 2005 and 2006. Components of the training include the following;

- EPI schedule;
- Cold chain maintenance at fixed centers;
- Registration and reporting;
- BCC messages;
- Community mobilization;<sup>25</sup>
- Caretaker counseling at facilities;
- Monitoring and Supervision;
- Calculating targets, coverage rates;
- Graphic displays; and
- Microplan Development.

---

<sup>23</sup> A Basic Package of Health Services for Afghanistan. Transitional Islamic Government of Afghanistan Ministry of Health, March 2003, p 16.

<sup>24</sup> Communication with Provincial Health Director.

<sup>25</sup> CS-19 will use SC technical capacity and innovative methodologies on community mobilization to train the MOH and NGOs participating in BPHS EPI activities. The recent manual on community mobilization, co-developed by SC, will be used for all community mobilization activities in CS-19 interventions (*How to Mobilize Communities for Health and Social Change: a field guide by Lisa Howard-Grabman and Gail Snetro, 2003.*)



### 3. Monitoring and evaluation

Periodic joint supervision using an EPI monitoring checklist will be carried out to identify gaps in the knowledge and skills of staff, gaps in the logistics system, cold-chain maintenance, and management of routine data collection and reporting. CS-19 will work primarily with the EPI and HMIS officers at the PHO. CS-19 staff will address shortcomings through on-the-spot technical assistance, refresher courses, and/or joint planning to ensure appropriate managerial support to EPI services.

### 4. IEC tools

Through the structure of the PHCC, CS-19 will collaborate with the MOH and NGOs to identify and develop IEC tools for volunteers, MCH promoters and BPHS staff to promote quality EPI services and coverage.

## B. Control of Diarrheal Diseases

The CS-19 approach will be to build upon SC experience in the Andkhoy Cluster and the Shiberghan ARI/CDD Program through supporting the CDD-related activities in the BPHS IMCI plan. These activities include: IEC, case management of diarrhea, ORT, identification of danger signs like dehydration and bloody diarrhea, reporting and supervision/monitoring. At the health post level, CHWs and health workers will give ORS and counsel caregivers, and will refer cases of moderate to severe dehydration, persistent or bloody diarrhea to the BHC, CHC or DH.<sup>26</sup> Antibiotics and IV solution will be available at every facility level except the health post.

The CS-19 ARI/CDD Task Force<sup>27</sup> met for two days to discuss how CS-19 will support the ARI and CDD components of the BPHS. Results of this meeting, along with earlier stakeholder meetings during the DIP planning outlined needs for a TOT course on CDD, IEC materials development and training, joint supervision, CHW training as needed to supplement REACH activities, and training on monitoring and evaluation. The CS-19 CDD/ARI Officer will work with both the IMCI Officer and the Control of Communicable Diseases (CCD) Officer at the PHO to develop training tools on behavior change communication, health worker training, supervision and feedback to providers at BPHS facilities to improve the quality of care. TOT trainers will include ARI/CDD physician specialists in the Jawzjan MOH, along with the CS-19 ARI/CDD officer and other SC/US staff. Training participants will include relevant personnel from the PHO, MOH staff, and NGO counterparts at the provincial and district levels. Training curricula includes the national IMCI training guidelines as well as WHO/UNICEF materials. TOT components include:

- Education regarding diarrhea prevention, including hygiene and hand washing;
- Early recognition and home care (including ORT, continued feeding and breastfeeding, and increased feeding after the episode);
- Assessment and classification of levels of dehydration;
- Recognition of danger signs (dehydration, bloody diarrhea, persistent diarrhea);
- Appropriate treatments (ORT/RT);
- Caretakers' counseling;
- Community education and campaigns/messages;
- Follow-up and Referral;
- Management of ORS supplies and other essential drugs;

---

<sup>26</sup> A Basic Package of Health Services for Afghanistan. Transitional Islamic Government of Afghanistan Ministry of Health, March 2003, p 17.

<sup>27</sup> Task force members included Dr. Yonus Ghani, Chief of Internal Diseases (MOH), Dr. Khalil Haidari, Chief of Pediatrics (MOH), Dr. Anwar Rasuli (HMIS Officer, PHO), and Dr. Honey Muhammed, CS-19 Coordinator. CS-19 Afghanistan: *Provincial Strengthening*. DIP Draft. Save the Children, April 2004.

- Supervision (use of checklists<sup>28</sup>);
- Benefits and harms associated with traditional beliefs and practices;
- Development of diarrhea case report forms;
- Case management for providers at each level of care; and
- Use of monitoring and evaluation tools.

Additional trainings will be provided upon request in collaboration with the MOH and/or REACH to supplement REACH trainings and activities at the community and district level. However, the participants in the TOT will facilitate the majority of subsequent trainings to health workers (doctors, nurses at DH, CHC, BHC, and OPD), pharmacists, health educators and CHWs. Materials for the training will be translated into local languages, and the CS-19 ARI/CDD Officer will work with REACH staff to develop BCC messages for caretakers regarding danger signs, home care including ORS preparation, and prevention including hygiene.

Through REACH, health workers will be trained in sick child management and the national IMCI algorithms, and each BHC, CHC and DH will have adequate amounts of essential drugs and ORS. However, there remain some health facilities that are not currently supported through REACH, and will need essential drugs. At the request of the MOH, CS-19 will be supporting six clinics in non-REACH areas of Jawzjan Province (refer to Strategy #1 for further information), and will work with UNICEF and the MOH to mobilize support for the remaining facilities.

The ten CS-19 MCH promoters will attend the TOT, and will be responsible for training all CHWs working in each MCH promoter catchment area, using sections from the national IMCI curricula as well as the MOH CHW training guidelines, still in development at the time of this writing. The CHWs will attend monthly meetings at the BHCs and CHCs in their areas to address difficulties experienced in the health posts, or to provide assistance with completion of the monthly reporting forms.

CS-19 will draw upon the baseline findings and discussions with the PHCC and PHO IMCI Officer and CCD Officer to identify additional gaps in provider capacity<sup>29</sup> and develop supervisory checklists and training modules on essential drug management for health workers.<sup>30</sup> CS-19 will jointly supervise with the MOH in the analysis of these checklists, and will give technical assistance and refresher trainings as needed to strengthen the capacity of MOH staff.

### C. Pneumonia Case Management

The main features of ARI in the BPHS include ARI case management at all four levels of care; “mild cases” (cold, cough, fever, meaning “cough or cold, no pneumonia”) will be treated at health posts, non-severe pneumonia will be treated at the BHCs, and severe cases of pneumonia treated at the CHCs and DH. CHWs will treat “simple cases” (non-severe pneumonia) with cotrimoxazole at the health post, and other antibiotics, oxygen and nebulizers will be available at the next three levels of care.<sup>31</sup>

<sup>28</sup> Once every three months, BASICS checklists (observation and exit) will be used to monitor provider skill and quality of care. CS-19 will work with the PHO counterparts in joint supervision and monitoring, with feedback to REACH managers.

<sup>29</sup> For example, the KPC from Jawzjan found that 86% of providers provide anti-diarrheals to treat diarrhea in children, and only 37% of private practitioners suggested ORS.

<sup>30</sup> Communications with Dr. Iqbal, REACH provincial coordinator, included planning the collaboration of SC/US and SC/UK in providing trainings to CHWs to treat DD and ARI, in support of BPHS IMCI protocol. Training curricula for CDD will come from the national CHW training package (not yet available), and adapted locally, if needed.

<sup>31</sup> A Basic Package of Health Services for Afghanistan. Transitional Islamic Government of Afghanistan Ministry of Health, March 2003, p 17.

The CS-19 CDD/ARI Officer, along with other SC/US staff and experienced MOH ARI physicians<sup>32</sup>, will provide a TOT on ARI to the PHO IMCI and CCD Officers, along with other NGO counterparts and 18-22 physicians from all BHCs, CHCs, and the DH. The training curricula includes the national IMCI training guide, the ARI section from the national CHW training package, WHO/UNICEF protocols, and specific input from the CS-19 ARI task force.<sup>33</sup> Training components include the following:

- Assessment of children with ARI (under 2 mo, and 2 mo-5 yr);
- Classification of ARI;
- Treatment;
- Caretaker counseling;
- Home care and education;
- Follow-up and referral;
- Community education (including education incorporating traditional beliefs surrounding ARI and campaigns);
- Essential drugs and management;
- Supervision (use of checklists);
- Management of severe/complicated cases at the DH; and
- Monitoring and evaluation.

Additionally, CS-19 will develop training modules on ARI essential drug management, and will hold trainings as needed for CHWs. Some health facilities (for example, in Shibergan district) are not supported by REACH and may need additional support (refer to Strategies Section, #1, for further information.) CS-19 will appoint one MCH promoter for each BHC, who will work with BHC staff and attend CHW monthly meetings. The MCH promoters will attend the TOT course mentioned above, and will be responsible for providing a five-day ARI training to CHWs working in their facilities catchment area.

The BPHS currently supports case management of childhood illnesses at the BHC, CHC, and DH levels. CS-19 will train and support one literate CHW per village to treat pneumonia and diarrhea on a pilot basis. If found to be feasible and successful in this setting (refer to Strategies Section, #5 (Community Case Management) for further information.),<sup>34</sup> this approach will be scaled-up.

#### D. Nutrition

CS-19 will support the following BPSH nutrition activities: IEC about nutrition and growth, breastfeeding support, GMP, multi-micronutrient supplementation/fortification (CS-19 will focus efforts on iodine), diagnosis and treatment of malnutrition, community-based malnutrition management, reporting, supervision and monitoring.<sup>35</sup> CS-19 will offer support at the provincial level through the following:

---

<sup>32</sup> Physician trainers include Dr. Khalil, chief of Pediatrics, with 12 years experience in ARI/CDD and Dr. Yonus Ghani, chief of Internal Diseases, with 14 years experience in ARI/CDD. SC/US technical staff include Dr. Rahila, Dr. Dina and Dr. Qaadar.

<sup>33</sup> Task force participants included Dr. Khalil, Dr. Ghani, Dr. Rasuli, HMIS officer for MOH, and Dr. Honey, CS-19 Coordinator.

<sup>34</sup> REACH managers in Jawzjan Province have indicated interest in and support of the SC/US CCM strategy in coordination with BPHS activities for ARI.

<sup>35</sup> A Basic Package of Health Services for Afghanistan. MOH, March 2003. Page 18.

CS-19 Afghanistan: *Provincial Strengthening*. DIP Draft. Save the Children, April 2004.

## 1. Promotion of household use of iodized salt

An iodization factory recently opened in Shibergan city that will serve all of Jawzjan. REACH, along with UNICEF, will provide logistics support for the management and distribution of iodized salt to the shopkeepers and households. CS-19 will work with the Nutrition Officer at the PHO to develop IEC, community mobilization, and community socialization materials and trainings to raise community awareness around the need for iodized salt. The CS-19 BCC officer will be the point person for coordinating these activities, and for providing feedback to the PHCC and other stakeholders.

## 2. Positive Deviance/Hearth

CS-19 will introduce the Hearth model using the Positive Deviance Approach to identify and disseminate local positive MCH practices that contribute to child health. SC nutrition surveys showed chronic malnutrition (stunting) rates of around 50%, and acute malnutrition, (or wasting, defined as  $-2$  WHZ and below) at 14.5% in the 6-29 month-old category.<sup>36</sup> Whereas the rate of acute malnutrition is not alarmingly high, SC/US data show that feeding practices (early breastfeeding, exclusive breastfeeding, complementary foods and diet) are poor in the Jawzjan Province. CS-19 baseline qualitative studies indicate that some mothers do not understand the concepts of immediate and exclusive breastfeeding, and will discard colostrum because they perceive it to be dirty or harmful to the newborn. Weaning foods often have poor nutritional value, and mothers customarily give children tea and foods heavy in carbohydrates and low in protein. Therefore, the PD/Hearth Program will offer a forum for mothers and other caregivers to learn and discuss appropriate foods for infants and children, and how to avoid potentially harmful practices like giving infants opium to put them to sleep.

The Hearth Program will train CHWs and female nutrition volunteers in community mobilization techniques to prepare communities for Hearth. Selected communities will have either a high rate of malnutrition in children under 2 (approximately 30%) or have demonstrated poor understanding of appropriate breastfeeding, weaning and child feeding practices.<sup>37</sup> The health staff will then conduct a Positive Deviance Inquiry (PDI) to identify families that have poor resources but healthy children.<sup>38</sup> The Hearth Program will use the information gained about healthy child care and feeding practices demonstrated by the PD families to inform program development. These behaviors will be shared with program participants and neighbors to promote learning new community norms for child care and feeding. Each month, over a two-week period, caretakers of malnourished children (identified through regular growth monitoring) will be invited to participate in daily Hearth sessions in the home of a volunteer mother. The goal of these sessions will be to rehabilitate their children and discuss child health and nutrition education informed by the PD behaviors and foods identified through the PDI. The Hearth educators will supervise the mothers preparing a nutritious meal and

---

<sup>36</sup> Referenced in SC/US Afghanistan Field Office research findings on Breastfeeding and Weaning Beliefs and Practices, included in the Annex section of this document.

<sup>37</sup> CS-19 will work with the Nutrition Officer at the MOH level to train NGOs in selecting communities/geographic areas in which PD/Hearth will be an appropriate intervention.

<sup>38</sup> The PD/Hearth model presents affordable, sustainable, community-based nutritional rehabilitation and prevention of childhood malnutrition. The approach is based on “positive deviance” (PD), the observation that communities with few resources will include a few families with the same resources, but who have found solutions to common problems—in this case, child malnutrition. These positive deviant families have well-nourished children in a community in which many other families have mild- to severely-malnourished children. The positive deviance method identifies these families through a Positive Deviance Inquiry (PDI), catalogues the feeding practices (including breastfeeding), child care, and health-seeking practices which have enabled them to have healthy children. These findings inform the development of the Hearth program, explained above.

feed it to their children. Mothers will contribute to the planning of the nutritious meal, and will also contribute a food item each day. CHWs and health volunteers, selected and trained by MOH and participating NGOs, will present and discuss key messages at each of the Hearth sessions.

CS-19 will work with the MOH Nutrition Officer, Training Officer, and IMCI Officer and will use already-developed materials by SC and others<sup>39</sup> as well as Nutrition guidelines from UNICEF to provide a TOT on PD/Hearth and Nutrition and technical support to the MOH and interested NGOs participating in REACH. Components of the training will include the following:

- Determining the feasibility for Hearth in a given area (situation analysis);
- Community mobilization;
- Weighing children, and plotting on GM cards, and the GMP reporting system;
- Referral system for children falling below the desired WAZ;
- Monitoring children through GMP;
- Nutritional assessment of children attending HF;
- Caretaker counseling on nutrition and child development;
- BCC messages for exclusive breastfeeding, weaning, and feeding/breastfeeding during illness;
- Training Hearth staff;
- Conducting and analyzing the PDI;
- Programming Hearth into existing GMP and MCH activities;
- Implementation of the Hearth model; and
- Monitoring and evaluation.

The BPSH prioritizes nutrition as critical to child health in Afghanistan, and the PHCC have requested training and BCC materials support from CS-19 on PD/Hearth. This activity complies with the “community-based management of malnutrition” component in the BPHS.

### 3. Behavior Change Communication materials

The CS-19 BC officer will work at the provincial level to support the IEC materials development and provide technical training as needed in the Nutrition IEC portion of the BPHS plan (refer to Strategies Section #2 for more information on the CS-19 BCC strategy.)

#### E. Maternal and Newborn Care

The MNC component of CS-19 will support the BPHS interventions in maternal and newborn health, delivery care, postpartum care, and care of the newborn.<sup>40</sup> REACH funding will provide materials and essential drugs for these interventions. Family planning activities outlined in the BPHS will be

---

<sup>39</sup> Examples of available tools include: TOT Workshop on PD/Hearth produced by The CORE Group, 2003; A Field Guide to Designing a Community-based Nutrition Program Using the Hearth Model and the Positive Deviant Approach by Monique Sternin et al, Save The Children, 1998; and Positive Deviance/Hearth: A Resource Guide for Sustainably Rehabilitating Malnourished Children, The CORE Group, 2003.

<sup>40</sup> An extensive list of services offered at all four levels of care is outlined on pages 11-15 in the Basic Package of Health Services for Afghanistan.

phased in at a later-stage of the REACH funding period, and CS-19 will support these activities as requested by MOH or REACH on a minimal basis.<sup>41</sup> CS-19 will support the following activities:

1. Refresher trainings for MOH staff, female doctors and MCH Assistants that will focus on the following:

- Reproductive health;
- Safe motherhood, including birth planning and child spacing;
- Newborn care;
- Communication and counseling skills;
- Specific needs of teenage mothers;<sup>42</sup>
- Encouraging mothers to bring family members to clinics to receive training on clean deliveries; and
- Educating mothers on the importance of postpartum care at the facility level or at home (this includes one high dose of Vitamin A to the mother, information on exclusive breastfeeding, and nutrition during lactation.)

2. Capacity-building for staff at regular antenatal clinics at all MOH facilities on birth planning.<sup>43</sup>

3. Collaboration with REACH for the recruitment and training of local female staff at MCH clinics;

4. Offer trainings as needed to existing TBAs to upgrade their skill level to that of CHWs, in collaboration with planned REACH CHW and midwife trainings.<sup>44</sup>

5. SC MNC activities in the Andkhoy Cluster (pre-CS-19) will continue with REACH midwives, and nurses based in the three area BHCs and CHC.

6. Trainings to the PHO RH Officer and the Training Officer on community mobilization which include collaboration with community leaders to develop systems for emergency transportation to the nearest health facility with Basic Emergency Obstetric Care (BEOC) services, or to the CHC or DH for comprehensive obstetric care.

7. Support to REACH staff to strengthen BEOC, including management of hemorrhage, through the training of female doctors and nurses, and female master trainers using UNICEF and IMPAC training guidelines.

The MNC task force<sup>45</sup> developed the training agenda for the TOT course on MNC for the MOH RH Officer, the Training Officer, and NGO staff providing REACH-funded MNC services. Trainers will

---

<sup>41</sup> The level of effort for MNC through CS-19 has increased at the request of the PHCC members. Although CS-19 dropped Family Planning as a specific intervention to coordinate better with the BPHS REACH strategy, some FP components have been subsumed into the MNC intervention.

<sup>42</sup> Experience and materials from SC/US Afghan refugee program in Haripur, Pakistan will be used and adapted for this population.

<sup>43</sup> All antenatal clients and family members will receive counseling on birth planning, the importance of home care and rest, the importance of having a skilled birth attendant, danger signs and appropriate actions to take, and local transportation options for quickly assessing care.

<sup>44</sup> New MOH policy prohibits the use of TBAs.

<sup>45</sup> Task force members included Dr. Muyassar Habibi, chief of the OB/GYN ward, Dr. Rahmatullah, Director of the MOH District Hospital, Dr. Mina, Andkhoy Health Officer and MCH trainer, Dr. Delsuz, Health Officer, and Dr. Honey, CS-19 Health Coordinator.

include the CS-19 RH Officer, two OB/GYN MOH physicians with experience in MCH training and two SC MCH trainers. In addition to the PHO Officers, other TOT participants will include four female doctors at the district level and the midwives and MCH promoters currently working in the BHCs and CHCs. Materials will include national guidelines developed by UNICEF and the MOH. Guidelines from WHO and UNICEF have been translated into local languages and will be used for BEOC. Midwife training guidelines (see Strategy Section, #1, for more information on CS-19 midwife training) are available through ICRC, and national guidelines are currently under development. In keeping with the PHO and MNC task force recommendations, the TOT will be a seven-day training, and will cover the following key topics:

- Knowledge and skill development surrounding antenatal care;
- Pregnancy testing and medical history;
- Danger signs;
- Identification of risk factors;
- TT vaccination and schedule;
- Nutrition, including iron and folic acid supplementation;
- Counseling skills (including special counseling for teenage mothers);
- Childbirth
  - Danger signs
  - Clean delivery and use of clean birth kits
  - New TBA policy and descriptions of skilled birth attendants
  - BEOC and CEOC
- Postnatal care
  - Elements of postnatal care for mothers and for newborns
  - Danger signs in mothers and newborns
  - Referral
  - Family planning and counseling
- Birth planning
  - Community-based referral (alarm and transportation)
- MNC registration and reporting
  - ANC, delivery and postnatal registration
  - Monthly MOH HIS report forms
- Joint supervision and use of supervisory tools
- Community awareness and education
  - Health education methodology
  - Health education messages
  - Importance of follow-up care for new mothers
  - Role of CHWs, community midwives, and midwives (including discussion of old role of TBAs and compliance with MOH policy)
  - Community education, including campaigns and key messages

In addition to the TOT, CS-19 will support district and community-level trainings as needed and requested by the MOH and REACH for health providers in HPs, BHCs, CHCs, OPDs and the DH. Although existing TBAs will no longer attend births per MOH policy, CS-19 will work with REACH staff to provide these female TBAs, in addition to female traditional healers, with refresher training on birth planning, family planning, and other MNC topics in order to become community educators. There are a total of 127 CHWs in Jawzjan who will receive MNC training through REACH (SC will train 127 CHWs in Jawzjan, including the Andkhoy Cluster.) Each CHW will be located at a health post and will be trained in referrals and record-keeping to follow pregnant

women and new mothers in their communities. CS-19 will support technical refresher trainings for CHWs upon request.

The role of the CS-19 RH Officer will be to plan supervisory visits with her MOH counterparts, develop supervisory checklists that will be analyzed every three months, with feedback to the MOH, and REACH. Refresher training to facility staff will be provided through joint collaboration of CS-19 and REACH as needed. Additionally, once every three months, the CS-19 RH Officer will conduct a Safe Motherhood exit checklist and an observation checklist during antenatal care visits to monitor the quality of MNC services.

### CS-19 Objectives Support CSHGP Intermediate Results

The CS-19 Results Framework<sup>46</sup> aligns with CSHGP IR-1<sup>47</sup> by addressing use, coverage and quality of MCH services, IR-2<sup>48</sup> by addressing sustainability of MCH programs, and IR-3<sup>49</sup> by addressing the development and application of tools and strategies to improve MCH programs. SC and CS-19 will draw upon the program successes and staff capacity from the Andkhoy MCH programs to inform the provincial-level strengthening in Jawzjan Province. The CS-19 efforts to strengthen the foundation of support for MCH programs at the PHO level will not only support the REACH-funded BPHS activities, but will build the capacity of key provincial health officers and providers to sustain effective MCH programs after the three-year REACH project ends. Adapting, testing and scaling-up CDQ and CCM through CS-19 supports the achievement of CSHGP IR-3.

Through CS-19, SC seeks to work with the MOH and NGOs by providing essential MCH services and bring SC experience in program-design to each of the interventions, innovative approaches and strategies. In addition, CS-19 will offer technically-sound trainings, joint supervision, and assistance with the monitoring and evaluation of health activities that is essential at this time of sweeping policy and programmatic change in Afghanistan.

## **2.1 Cross Cutting Strategies**

CS-19 will address priority MCH needs in the above intervention areas through the implementation of four cross-cutting strategies, designed to support the BPHS and organizations funded through REACH to provide BPHS activities. Thus, the principle strategy of CS-19 is *provincial-level strengthening of the MOH in Jawzjan through training, capacity-building of the PHO, and supervision to effectively support the BPHS*, the process of which is discussed throughout this document. Two additional major activities related to this strategy, and not included in Section 2 (Program Description by Objective, Intervention and Activities) are 1. Support for 6 clinics in Shibergan District, and 2. Support for an MOH Community Midwife Training. These are described in detail below:

---

<sup>46</sup> See page 39 of this document.

<sup>47</sup> CSHGP IR-1: "Increased use, coverage and quality of child and maternal health, and nutrition and infectious disease programs implemented by PVOs and their local partners."

<sup>48</sup> CSHGP IR-2: "Increased sustainability of child and maternal health and nutrition and infectious disease programs/interventions initiated by PVOs and their partners."

<sup>49</sup> CSHGP IR-3: "Child and maternal health and nutrition and infectious disease program strategies, tools and approaches developed/adapted, tested, and applied."



## 1. Support for 6 clinics in Shiberghan

Dr. Haroon, MOH Director and Provincial Health Director for Jawzjan Province, requested support for 6 rural clinics in Shiberghan which are not supported through REACH funding. These clinics provide services for a large rural population, and will close without support. Each clinic will follow BPHS staffing guidelines, and will have eight staff at each location: one physician, one technician, one nurse, one midwife/auxiliary midwife, two vaccinators (one male, one female), and two support staff. The clinics, distance from Shiberghan city and approximate population in the catchment areas are included below.

**Table 8. CS-19 Supported Clinics**

<b>Clinic Name</b>	<b>Distance from Shiberghan city (kilometers)</b>	<b>Approximate Population Reached</b>
Jaghsai	6	8,000
Baba Ali	8	11,700
Yangi aregh	14	12,600
Qawchin	15	8,500
Qara darya	20	6,700
Afghan Tapa	25	9,700

UNICEF has agreed to provide the essential drugs in each clinic, and CS-19 will provide the transportation for clinic staff to and from each clinic for the duration of the project. A plan for continued support after CS-19 phase-out is under development with the MOH, UNICEF, and CS-19 staff. Transportation costs will average five USD, or approximately 221 Afghanis.

## 2. Community Midwife Training

The MOH in Jawzjan has selected 40 candidates with the necessary pre-requisites under national guidelines for midwife training, and has requested support from CS-19. The MOH will provide the training site, and CS-19 will provide the trainers (CS-19 technical staff, MOH Midwife Trainers, and selected physicians), room, board, and all needed training materials. Candidates have signed contracts stating that, upon certification, they will return to their communities and work in rural areas of Jawzjan. According to the *National Policy of Human Resources Development for Health* (draft, June, 2003) the MOH requires that all NGOs “use the national standardized curricula”, which is currently being finalized and will incorporate the following components:

- antenatal and postnatal care;
- case and support during delivery, including newborn care;
- diagnosis and management of common maternal and newborn emergencies;
- stabilize and refer cases that require advanced care (e.g. eclamptic fits, septic shock); and
- family planning and early newborn care.

Other guidelines informing the Community Midwife Training include: *A Learning Resource Package for Community Midwife Education (REACH)*, *Infection Prevention Guidelines for Healthcare Facilities with Limited Resources (JHPIEGO)*, *Basic Maternal and Newborn Care (JHPIEGO)*, *IMPAC: Managing Complications in Pregnancy and Childbirth: A Guide for Midwives and Doctors (WHO)*, and *IMPAC: Managing Newborn Problems (WHO)*. CS-19 will

work with the MOH, REACH and UNICEF to ensure the CS-19 training conforms to national guidelines and policy, as well as to future REACH planning for midwives in Jawzjan.

The second CS-19 cross-cutting strategy, *health behavior change activities through health facility staff, CHWs, mullahs, teachers, midwives, mothers-in-law, and local radio*, addresses the BCC activities, technical assistance and training components within the CS-19 design. The CS-19 BCC Officer will work with counterparts at the PHO and NGOs to provide technical assistance in developing materials and messages for the five CS-19 intervention areas. CS-19 will provide a BCC training and refresher course, and will focus on messages that can be delivered via formal (e.g. facility staff) and informal networks (e.g. mothers-in-law.)

The third strategy, *CS-19 engagement with health sector partners to leverage resources in support of essential MCH activities in Jawzjan*, will involve working through the PHCC, made up of BPHS NGOs and other stakeholders, to identify priority MCH needs unmet by existing funding mechanisms and to create action plans for quick response.

The fourth strategy of CS-19 is *testing innovative approaches to improving access, quality, and use of essential MCH services; documentation and dissemination of feasibility and results; and scaling-up of successful approaches*. CS-19 will bring three innovative approaches (Community Case Management, Community Defined Quality, and PD/Hearth) to Jawzjan for piloting, assessment, and potential scale-up. Training and implementation of these approaches have been requested and encouraged the NGO community implementing the BPHS.

CCM will increase community access to and prompt use of life-saving treatment for childhood diarrhea and pneumonia by training and supporting CHWs to provide this service in areas with poor access. CS-19 staff will work with health sector partners in Jawzjan to define “poor access” areas, and identify CHWs for training in CCM. Training activities will include a practice at a health facility in assessment of ill children and counseling of mothers, and viewing and discussion of the WHO ARI case management video. CHWs will be required to successfully pass an assessment of their case management skills before being allowed to treat children in their communities. Beeping timers or watches with second hands will be provided to all CHWs trained in CCM. SC MCH Promoters, MOH staff, and the PHO IMCI Officer will closely supervise the CHWs. CS-19 will assess the quality of case management, the extent of community use of this service, and feasibility for scale-up to other areas with poor access to case management services.

CS-19 staff will present the concept of CDQ to the PHCC and select partners for implementation in pilot sites. In these sites, community members work with health service providers to define what quality MCH services mean from the perspectives of both groups, share these perspectives between the two groups, and plan and implement activities together to improve quality and increase use of these services. CS-19 will use SC materials<sup>50</sup> and will offer a training on PDQ to NGOs implementing the approach in the pilot areas. CS-19 will document the feasibility of CS-19 in these areas, and if successful, will scale-up CDQ to other areas of Jawzjan. Information will be analyzed and results shared with community leaders, health providers, the MOH and PHCC.

A PD/Hearth training, requested from the MOH and other NGOs working with child nutrition in Jawzjan, will be provided through CS-19 and pilot sites selected for initial implementation. This training is outlined in Section E.2., section D (Nutrition.)

---

<sup>50</sup> Partnership Defined Quality: a tool book for community and health provider collaboration for quality improvement. Save the Children, 2002.

## 2.2 Behavior Change & Communication

### How CS-19 will work to influence change in those behaviors that negatively impact the health of women and children.

The current beliefs, knowledge, and practices/care-seeking behaviors of mothers, families, and other caretakers will be influenced by CS-19 through:

- Community mobilization trainings for the PHO
- Interactive engagement of local health workers with community groups to promote improved MCH practices
- Several districts in Jawzjan have shown interest in the development of Community Health Councils, which CS-19 will bring to the agenda of the PHCC as they develop their BCC plans
- Health behavior change activities planned through health facility staff, CHWs, mullahs, teachers, children, and local radio. These activities will be vetted through the PHCC, with CS-19 taking a lead role in BCC trainings and materials development.
- PD/Hearth
- CDQ
- Improving access to and use of essential MCH services through CS-19 MCH promoters.

(Please see the section above on CS-19 strategies for discussion of these approaches. The table below includes behaviors of mothers, families, and health providers, and CS-19 activities to influence these behaviors.)

### How information from research will be used to contribute to changes in practices

The project has conducted, and/or will conduct, research using the following methods:

- Behavior or audience assessments: KPC Surveys; Positive Deviant Inquiries; Focus Groups;
- Environmental assessments: PRA; Focus Groups; Integrated Health Facility Assessments; Gap Analysis; and
- Pretests and trials of behaviors: Hearth Model, CDQ, CCM.

(Please refer to the table below for discussion of how the information will be used. Findings from these assessments have been and will be incorporated into CS-19 behavior change activities and materials.)

### BCC-related training and supervision plans

Please see the section above on the CS-18 strategy of joint training and supervision and detailed training plans in Annex 8.

Activities that will be carried out to facilitate behavior change at each level

**Table 9. CS-19 BCC Activities by Audience**

<b>Audience</b>	<b>Behavior</b>	<b>Key Factors Influencing the Behavior</b>	<b>Planned CS-19 Activities</b>
<b>Individual</b>			
Mothers who have children less than 5 years of age	Use iodized salt for cooking	<p>Increasing family knowledge about the benefits of iodized salt, stressing its importance for increasing IQ of children.</p> <p>Increasing PHO capacity and knowledge of the importance of supporting use of iodized salt as a key behavior at all levels of facilities</p> <p>Changing health worker knowledge/ attitudes from cure/treatment to prevention and importance of iodine for improving IQ of children.</p>	<p>BCC materials and key messages development</p> <p>Training for PHO-level staff</p> <p>Training for health workers</p> <p>Promoting iodized salts each time caretakers visit HF for consultation</p> <p>Iodized salt promotion by mobilizing community shopkeepers (in collaboration with UNICEF)</p>
	Demand an immunization card for her child and visit the HF at the time of next scheduled vaccination of her child	<p>Increasing family knowledge on importance of immunization</p> <p>Increasing family knowledge on importance of immunization schedule</p> <p>Increasing family knowledge of preventable diseases through immunization</p> <p>Changing health workers attitudes on timely, planned immunization sessions</p>	<p>Training for PHO-level staff</p> <p>Training for health workers</p> <p>Promotion of Mother-Based Immunization cards</p> <p>Incorporating community perspectives into EPI (through CDQ process)</p>
	Demand Road to Health cards, and that their children are weighed for growth monitoring	<p>Increasing mothers' knowledge on nutrition</p> <p>Increasing health worker knowledge on nutrition</p> <p>Increasing mother and health worker knowledge on BF (duration, definition of exclusive)</p> <p>Increasing knowledge of proper time and foods for weaning</p> <p>Changing health workers attitude about proper weaning food &amp; time to prevent children from malnutrition</p>	<p>Training to PHO staff</p> <p>Training to health workers</p> <p>Promotion of Growth monitoring cards</p> <p>Improving coordination and partnership among PHCC members</p> <p>Identifying "positive deviant" children, foods, and other behaviors and educating mothers with malnourished children during Hearth sessions.</p>
	Mothers wash their hands with soap/ash before	Increasing knowledge about the causes of diarrheal diseases.	<p>Training on CDD to PHO staff</p> <p>Training on CDD to health</p>

	food preparation, child feeding, and after defecation & child defecation	<p>Increase knowledge about clean hands will prevent diarrhea in children.</p> <p>Increase health worker capacity to provide community case management of diarrhea.</p>	<p>workers as requested by MOH</p> <p>Training on CCM in piloted communities</p> <p>Visual aids and key messages displayed at health facility</p>
	Mothers take their child to the health provider on early recognition of danger signs of diarrhea & pneumonia	<p>Increasing knowledge about danger signs of DD and pneumonia</p> <p>Changing attitude of early care seeking at HF</p> <p>Changing attitude of health workers in the management of DD and ARI cases.</p>	<p>Training to PHO staff</p> <p>Training to health workers</p> <p>Training on CCM in piloted areas</p> <p>Coordination with REACH on providing logistics or management support for essential drugs at all facility levels</p>
	Mothers increase fluids & continue feeding their child when ill with ARI & Diarrhea	<p>Increase knowledge about home management of diarrheal diseases</p> <p>Increase knowledge on nutrition and ways to prevent malnutrition in the children</p> <p>Changing attitude of health workers about counseling for increased fluids and foods when sick children are brought for consultation</p>	<p>Training to PHO staff</p> <p>Training to health workers</p> <p>Identifying “positive deviant” mothers (mothers who increase fluids &amp; foods when their children are sick) and whose children are well nourished and demonstrating these to other community mothers.</p>
	Exclusively breastfeed their child till 6 months after birth	<p>Increasing knowledge about benefits of exclusive breastfeeding, stressing breast milk is sufficient nourishment &amp; liquid for the baby.</p> <p>Changing attitudes about the nourishment for the baby</p> <p>Increasing the knowledge/attitude that breast milk has all the immunity for the child</p> <p>Changing health worker knowledge/attitude about poor, malnourished mothers being able to provide sufficient nutrition through breast milk.</p> <p>Changing mothers’ belief that colostrums is harmful to the child</p> <p>Changing mothers practice and belief of using opium to lull a breastfeeding child to sleep</p>	<p>Training to PHO staff</p> <p>Training to health workers</p> <p>Development of key messages for mullahs, teachers, and other respected community leaders on the benefits of BF</p> <p>Promoting growth monitoring cards</p> <p>Promoting breast feeding during antenatal visits</p> <p>Assuring adherence to national policies through the development of checklists, and plans for monitoring and evaluation.</p> <p>Identifying “positive deviant” mothers (poor, malnourished) who exclusively breastfeed and whose infants are thriving.</p>

<b>Pregnant women</b>	Visit the health facility for antenatal check up.	<p>Increasing knowledge of the importance of antenatal care</p> <p>Increasing knowledge of safe delivery &amp; detection of any complications during antenatal checkups</p> <p>Increasing knowledge of importance of birth plans during antenatal care</p>	<p>Training to PHO staff</p> <p>Refresher training to community midwives, midwives and doctors</p> <p>Training of new midwives</p> <p>Training health workers in life-saving skills</p> <p>Coordinating with PHCC to develop birth plans involving the pregnant woman, husband, midwife, and health staff</p> <p>Assuring adherence to new MOH policies through monitoring plans</p> <p>Develop plans with MOH and PHCC on shifting away from utilizing TBAs</p>
	Pregnant women demand and utilize iron / folic acid supplements	<p>Increasing the knowledge about Anemia and its complications</p> <p>Increase knowledge of factors contributing to anemia and ways for prevention</p> <p>Changing health worker knowledge/ attitude towards prescribing iron supplements to all pregnant women</p>	<p>Training to PHO staff on micronutrients</p> <p>Training to health staff</p> <p>Midwife training</p> <p>Development of messages for health talks by midwives</p> <p>Identifying “positive deviant” mothers (poor who utilize iron supplements during pregnancy and whose infants are thriving).</p>
	Develop birth plans	<p>Increasing knowledge of different components of birth plans</p> <p>Increase knowledge on importance of birth plan and the importance of involving husband and/or other family members</p> <p>Importance of Emergency Transportation plans</p>	<p>PHO training</p> <p>Midwife training</p> <p>Birth planning sessions involving pregnant women, husband, and MOH midwife/staff</p> <p>Developing Emergency Transportation plans with PHCC</p> <p>Developing monitoring and supervisory plans</p> <p>Development of messages for midwife talks during antenatal visits</p>

	Delivery assisted by a community midwife, midwife or doctor	<p>Increase knowledge about safe and clean delivery</p> <p>Importance of skilled health personnel attending the delivery</p> <p>Increased knowledge about the complications during delivery</p>	<p>PHO training</p> <p>Midwife training</p> <p>Midwife talks during A/N care visits</p> <p>Strengthening the referral system in BPHS</p>
	Visit health facility for postpartum check up, and promptly upon early recognition of maternal and newborn danger signs	<p>Increase knowledge on postpartum danger signs</p> <p>Increase knowledge on newborn danger signs</p> <p>Changing attitudes of health workers about the importance of postpartum checkups</p>	<p>PHO training</p> <p>Midwife training</p> <p>Development of messages for midwife talks during antenatal care visits</p> <p>Birth plans including postpartum visits by the health worker</p> <p>Training workshops for health workers</p>
<b>Family/ Household</b>			
<b>Mothers-in-law</b>	Involved in birth plans and visiting the HF at least once with her daughter-in-law for antenatal care	<p>Increasing knowledge about the importance of antenatal care</p> <p>Increasing knowledge of safe delivery by detection of any complications during antenatal checkups</p> <p>Increasing knowledge of different components of birth plans</p> <p>Increase knowledge about importance of coordinating birth plans with a midwife</p> <p>Importance of Emergency Transportation plans (i.e. keeping some money available for emergencies)</p>	<p>Training to PHO staff</p> <p>Training to mother-in-laws</p> <p>Training health workers</p> <p>Development of messages for health talks by midwives</p> <p>Assuring adherence to MOH policies through monitoring and supervision plans</p> <p>Identification of “positive deviant” mothers-in-law (those who support their daughter-in-laws in birth planning, antenatal care, and learning about safe deliveries)</p>

	Family members who take care of the children in the absence of the mother, wash their hands with soap/ash before food preparation, child feeding, and after defecation & child defecation	<p>Increasing knowledge about the causes of diarrheal diseases.</p> <p>Increase knowledge about clean hands will prevent diarrhea in children</p>	<p>Training to health staff</p> <p>PD/Hearth messages</p> <p>Visual aids displayed at health facility</p>
	Family members take the child to the health provider on early recognition of danger signs of diarrhea & ARI	<p>Increasing knowledge about danger signs of DD and ARI</p> <p>Changing attitude of early referral to HF</p> <p>Changing attitude of health workers in the management of DD and ARI cases.</p>	<p>Training to PHO staff</p> <p>Training to health workers</p> <p>Training on CCM in pilot areas</p> <p>Developing checklists for monitoring and supervision</p>
	Family members increase fluids & continue feeding their child when ill with ARI & Diarrhea	<p>Increase knowledge about home management of diarrheal diseases</p> <p>Increase knowledge on nutrition and ways to prevent malnutrition in the children</p> <p>Changing attitude of health workers about counseling increased fluids and foods when sick children are brought for consultation</p>	<p>Training to PHO staff</p> <p>Training to health workers</p> <p>Training on CCM in pilot areas</p> <p>Identifying “positive deviant” mothers-in-law (MIL who support mothers who increase fluids &amp; foods when their children are sick, as well as supporting mothers with well-nourished children) who can demonstrate this support to other community mothers.</p>
	Mothers-in-law encourage mothers to exclusively breast feed their child until 5 months after birth	<p>Increasing knowledge about benefits of exclusive breastfeeding, stressing breast milk is sufficient nourishment &amp; fluid for the baby.</p> <p>Changing attitudes about the nourishment for the baby</p> <p>Increasing the knowledge/attitude that breast milk has all the immunity for the child</p> <p>Changing health worker knowledge/ attitude about poor, malnourished mothers being able to provide sufficient nutrition through breast milk.</p>	<p>PHO training</p> <p>Training to health staff</p> <p>Assuring adherence to BPHS policy through the development of supervisory and monitoring plans.</p>



<b>Husbands/ Men</b>	Involved in birth plans and will accompany his wife at least once during her antenatal care visit	<p>Increasing knowledge about the importance of antenatal care</p> <p>Increasing knowledge of safe delivery by detection of any complications during antenatal checkups</p> <p>Increasing knowledge of different components of birth plans</p> <p>Increase knowledge about importance of coordinating birth plans with midwives</p> <p>Importance of Emergency Transportation plans</p>	<p>Training to PHO staff</p> <p>Training to health workers</p> <p>Development of messages for health talks by midwives</p> <p>Assuring adherence to MOH policies through monitoring and supervision plans</p> <p>Developing Emergency Transportation plans and funds with PHCC</p>
<b>Community</b>			
<b>Community Health Committees</b> (developed in pilot districts of Jawzjan initially through CDQ process, then assessed for potential scale-up)	Regular assessment of the health needs and priorities	Increased knowledge of rights and responsibilities of communities in demanding and receiving quality care	<p>Regular monthly meetings with the HF staff</p> <p>Training workshop for PHO</p> <p>Training to NGOs implementing CDQ</p> <p>Training workshops for HF staff</p>
	Ownership of health activities including child survival and maternal health	<p>Increased knowledge and skills in community mobilization</p> <p>Increased knowledge of Primary Health Care, including Child Survival and Maternal Health</p>	<p>Improving coordination and building partnership between HF and Communities</p> <p>Joint planning sessions between community members and HFs</p>
<b>Institutional Systems</b>			
<b>Jawzjan MOH PHO staff</b>	Provide health education to the caretakers on EPI, ARI, DD, Nutrition & Maternal Health	<p>Increasing knowledge and skills on teaching methodologies to facilitate quality supervision of BPHS activities</p> <p>Building partnerships between the MOH and NGOs will lead to better coverage of health activities</p>	<p>Joint sustained projects (CCM, CDQ, PD/Hearth) with NGOs within Jawzjan</p> <p>Monthly PHCC meetings for coordination of activities</p>
	Analyze the monthly data collected including patient logs, immunization, growth monitoring records	<p>Increasing the knowledge on the importance of data collection and linking it to analysis, planning, and further implementation of the health activities</p> <p>Changing the attitude of the health workers about the reasons why and how data collected will be utilized</p>	<p>Data collection and analysis of the data on monthly basis through coordination with PHO</p> <p>Planning health activities jointly with MOH, PHCC, and community groups (in CDQ areas)</p> <p>Training workshops</p>

	Plan regular immunization sessions	<p>Increasing the knowledge about the importance of immunization, including proper techniques and cold chain</p> <p>Changing the attitude of the health workers about planned immunization sessions to increase immunization coverage and decrease vaccine wastage</p> <p>Increase the knowledge of the communities about the importance of immunization</p>	<p>Training to PHO staff</p> <p>Training workshops for HF staff</p> <p>Equipping HFs with basic recording reporting formats</p> <p>Training on analyzing coverage rates</p> <p>Regular coordination meetings at PHCC to plan immunization sessions (routine and NIDs)</p>
<b>Community Midwives</b>	Manage normal pregnancies, deliveries & obstetric complications according to the National & International protocols	<p>Increasing the knowledge and skills about management of normal pregnancies and deliveries.</p> <p>Changing practices about managing normal pregnancies, deliveries &amp; obstetric complications according to new National protocols</p> <p>Changing beliefs and practices to align with new MOH policy disallowing TBAs.</p>	<p>Refresher training workshops including clinical training for existing midwives</p> <p>Training of new midwives</p> <p>On-the-spot training during monitoring</p>

### 2.3. Quality Assurance

#### How QA methods will be applied to CS-19 interventions

Defining Quality: The project has defined quality ARI and DD case management by ensuring that the WHO ARI and CDD case management charts and wall charts in facilities are translated into Dari, and making sure these are posted in each MOH health facility in the CS-19 site. All CS-19 training materials will come from national guidelines and international sources (WHO/UNICEF), and any remaining guidelines (for example, the CDQ field guide, PD/Hearth training materials, and Community Mobilization guidelines) will be approved by the PHCC before use. Translation of these materials into Dari will be done by the SC staff translator in Shibergan.

In CDQ pilot sites, communities and providers will be defining quality, and applying those definitions to a jointly developed action plan to prioritize existing problems in health services, and create solutions to strengthen the quality, access and use of these services. The CDQ process will inform health programmers from the start-up of the BPHS implementation, and can be applied to services at all four levels of care. Results will be shared on an on-going basis with the PHCC, and planning for scale-up will be in collaboration with MSH, REACH-funded NGOs and the MOH.

Measuring Quality / Data-Based Decisions: The CS-19 baseline HFA used elements of the BASICS and WHO Safe Motherhood Needs Assessment tools to measure important aspects of quality service delivery at a sample of CS-19 rural health facilities with regard to each of the project's interventions. Health workers were observed as they provided MCH services and then they were interviewed. Exit interviews were conducted with mothers leaving the facilities, and facility equipment and supplies were reviewed. Regular joint supervisory visits to health facilities by SC and MOH staff will include measuring quality service delivery with the aid of checklists.

Use of referral forms with feedback to users will help in measuring quality of services. All monitoring and measurement of quality will be conducted in collaboration with the PHCC.

Improving Quality: Several CS-19 objectives relate to improved technical skills of provincial health staff who are responsible for district and community health workers in the new BPHS policy. Quality of MCH service delivery will be improved through trainings to PHO staff and providers with regard to all CS-19 interventions and innovative approaches such as CDQ, CCM, and PD/Hearth. These trainings will be reinforced through refresher trainings focused on problem areas identified through the HIS or during supervisory visits and meetings. Problems detected during supervisory visits will be addressed on the spot with health facility staff and will be discussed at monthly PHCC meetings. Efforts to strengthen preventive service and quality of care will also be reviewed in these meetings. In addition to technical quality, an important focus of the project is on improving access to MCH services. Access to services will be addressed through the increase in health staff through REACH funds, particularly the increase in female health workers. Equitable access to services is a focus in the BPHS and in CS-19, and the Equity Task Force, established and led by CS-19 staff, will create an action plan to identify gaps in access from the poorest or disenfranchised members of communities. Additionally, results from the CDQ process will identify areas for improving the quality of services, and will be shared with the PHCC and integrated into existing quality improvement strategies.

Teamwork: CS-19 will participate in monthly PHCC meetings that include all REACH-funded NGOs, national NGOs, MOH, and other providers. These meetings will be a forum to review health data, discuss progress and problems, and make decisions. Additionally, the CS-19 intervention-specific task forces (comprised of technical experts and program managers from partners) will meet twice yearly to monitor activities, and will report back to the PHCC to give all stakeholders an opportunity to learn about, reflect upon, and advise project implementation. The CS-19 trainings including components of community mobilization, and CS-19 staff will provide technical assistance to participating NGOs on increasing community participation in BPHS activities.

#### Training and supervision plans and sustainability of quality improvement

The CS-19 MCH Promoters will facilitate the implementation of CDQ at the selected sites, and together with the CS-19 BCC Officer, will document the quality improvement process and community mobilization efforts. SC experience in the CDQ process has shown that the Quality Improvement Committees continue long after project completion and NGO phase-out. Quality Improvement Committees (comprised of community members and providers) will continue to support improvements in the quality of facilities, and will work with NGOs to develop a sustainability plan after CS-19 phase-out.

### **2.4. Access: (1) Services; (2) Health-Related Products (Availability of Drugs, Vaccines, Micronutrients, Equipment, etc.)**

#### Commodities essential to the success of each intervention

Although the availability of a variety of commodities is essential for the delivery of effective MCH services through the MOH, CS-19 does not directly seek to ensure the availability of these essential commodities at rural health facilities. Instead, CS-19 seeks to build the capacities of rural health facilities and communities to jointly identify which commodities are required for essential MCH services and then to make these available through sustainable mechanisms. REACH funds will provide essential drugs at all facility levels. At the six clinics supported by CS-19 and not covered through REACH, UNICEF has committed to supplying a variety of essential MCH commodities for these facilities.

### Current reliability of supplies of essential commodities, and how supplies will be ensured during CS-18, including supply sources

During the CS-19 baseline child health HFA in the Andkhoy Cluster, 100% of facilities reported stock outs of essential medicines during all of the previous 30 days (data for Jawzjan was unavailable at the time of the baseline). Although this is not expected to be a problem with REACH funds, CS-19 will monitor facilities and will work through the PHCC to mobilize resources should any problems occur with supplies in Jawzjan facilities.

### Likely constraints to the success of “supply” activities, and approaches to overcome constraints

It is difficult at this time to identify constraints in supply activities, as BPHS activities and REACH funding is in the start-up phase. However, CS-19 will play an active role in monitoring this process and responding to needs in partnership with the PHCC.

### How the quality of supplies will be monitored (e.g. cold chain maintenance)

The supplies will be monitored during the joint SC/MOH supervisory visits. The monthly immunization reports and the supervisory checklists indicate the quality of the cold chain and immunization supplies. CS-19 will use checklists for each intervention area (see Annex 11 for the EPI example.)

### Training and supervision to build partner capacity and sustainability

CS-19 will train provincial level staff and partner NGOs with refresher trainings to build capacity in the CS-19 intervention areas. CS-19 technical officers will also provide ‘on the spot’ technical assistance throughout the life of the project, which extends two years beyond REACH funding. The CS-19 prioritization of capacity-building of MOH and provincial health staff, not funded through REACH, will increase sustainability and the continuing quality of supervision of BPHS activities.

## **3. Program Monitoring and Evaluation Plan:**

Current information system at site, relationship to CS-19 HIS, points of overlapping data, integration of CS-19 and other data, and of facility-based and community-based data. Monitoring and improving program and health worker performance, including plans for on-going assessments of essential knowledge, skills, and practices of health workers, and supplies/drugs/equipment of facilities; and CS-19 monitoring tools, including tools to promote quality of service and quality and coverage of intervention activities.

In CS-19 target areas, the MOH will be using a WHO-recommended HMIS system that was implemented in 2000 and covered data collection and reporting on EPI and safe motherhood activities and on mortality and morbidity. In addition, the MOH will be reporting on the REACH-recommended HMIS Health Facility Monthly Integrated Activity Report. This will include reporting on the:

- Function of facilities and CHW activities (staff availability, essential drugs, equipment, etc).
- CHW referrals, TBA-attended deliveries, CHWs/TBAs providing postpartum care.
- Facility/CHW-level family planning activities.
- Facility/CHW-level health education.
- EPI routine and outreach activities.
- Infection control and rubbish disposal.
- Supervision and monitoring.

In summary, CS-19 will help promote the MOH recommended HMIS system and will use the HMIS to report on project indicators. To report on CS-19-specific activities, the project will use its own reporting forms. For example:

#### Maternal & Newborn Care:

It is planned that through the REACH project, the REACH Project Officer, along with MOH staff, will visit all facilities and most CHWs on a regular basis. These visits will ensure that safe motherhood services, including family planning services, are well implemented both at the facility and community levels. Except in Andkhoy Cluster, to date the MOH does not have a system to monitor its safe motherhood services. With REACH project implementation and use of the HMIS Health Facility Monthly Integrated Activity Report, data collection and reporting on antenatal care, maternal nutrition, iron/folic acid supplementation, clean delivery, and postpartum care provided by CHWs and TBAs will start.

The CS-19 RH Officer will work together with MOH RH Officer and SC REACH Project Officer to develop training lesson plans to implement the HMIS Health Facility Monthly Integrated Activity Report, both at the facility and community levels. While this will help report on CHW/TBA activities comprehensively, CS-19 will make improvements in the REACH HMIS to include reporting on facility-based MNC services.

CS-19 will help implement MOH antenatal cards to be retained by the woman, to promote timely visits and tracking of antenatal care provided. Dates for the next scheduled ANC visit will be recorded on the card to remind the woman of the recommended date for her next visit.

CS-19 will also teach facility staff and CHWs how to present project activities visually (graphs, etc).

CS-19 will help the MOH develop supervision checklists that will promote identification of problems and “on the spot” technical assistance. These checklists will be used to observe the MNC skills of doctors, nurses, and CHWs, record status of supplies and equipment, and identify areas of concern. Information will be used to improve MNC services and support health facility staff and CHWs in their work. CS-19 will also field-test a checklist to interview clients of ANC and PNC clinics.

CS-19 will adapt and use MOH midwife monitoring forms. Health facility staff such as nurses will use this monitoring form once every two months to assess the work of midwives. The MNC Officer will use this form once every three months. Information gathered will be used to determine needs for further training, support, equipment and supplies.

#### EPI

At the facility-level, for the routine EPI program, the MOH uses UNICEF-recommended EPI registers for scheduling eligible children and women for immunization. An EPI daily record form is used to record daily EPI activities for childhood immunization and for TT separately. The information from these forms is entered in the permanent registers where each client is assigned a number and their immunizations received are entered. It is this register that will help the MOH develop a list of defaulters to implement outreach sessions through vaccinators and CHWs. The MOH will make monthly EPI reports from the permanent EPI registers.

The MOH has pictorial EPI cards for eligible children and women, which the clients keep and bring to immunization sessions to receive subsequent doses. Once or twice a month, the district EPI Supervisors visit the facilities to check the routine immunization sessions, deliver vaccines, and get monthly reports. Information on the campaigns (NIDs, measles and TT) is recorded in separate forms.

The CS-19 EPI Project Officer, the MOH EPI Officer, and the REACH Project Officer will develop training lesson plans to strengthen the existing MOH EPI HMIS (this is currently lacking in the REACH HMIS). They will then help integrate this with the REACH HMIS. The training will also focus on building capacity of health facility staff to use the EPI HMIS data to make EPI progress monitoring graphs, identify gaps, and make plans to address these. CS-19 will give computer training to both the EPI Officer and the MOH EPI Officer to ensure that an effective electronic HMIS is in place. EPI data will be analyzed and feedback given within a fortnight.

CS-19 will also copy Andkhoy MOH EPI supervision checklists for the EPI supervisors. These checklists will help identify progress, gaps, areas of improvements in cold chain maintenance, vaccination techniques, record keeping, and reporting. CS-19 will also help REACH and MOH staff to use WHO-recommended EPI surveillance forms.

#### ARI and CDD:

SC has substantial experience implementing ARI/CDD programs in different parts of Afghanistan. The MOH HMIS is limited to only reporting the number of ARI and diarrhea cases on the morbidity form on a monthly basis. While CS-19 will help continue this practice, it will also replicate SC's experience of supervising the implementation of ARI and CDD programs. Once every three months, the ARI/CDD Officer and MOH IMCI Officer will observe doctors and nurses to measure their effectiveness in the management of sick children (especially in regard to ARI, diarrhea and fever) using BASICS Health Worker's Observation Checklist. To assess the quality of services, including doctors' and nurses' counseling skills, caretakers will be interviewed using the BASICS Exit Interview Checklists. These interviews will be used to give feedback and to provide additional training to doctors and nurses. In addition, ARI reporting by health workers will be monitored regularly to ensure that all children with ARI are recorded in the patient log, indicating age of the child, respiratory rate, presence of chest indrawing, classification, and treatment.

CS-19 will also implement UNICEF's ORT checklist. This checklist helps in observing the health worker's performance in the ORT corner, records ORT supplies and equipment, and identifies problems. Information is used to improve diarrhea case management at the facility as well as the CHW level. All facilities, including HPs (CHWs), BHC, CHC and district hospitals, will have an ORT corner.

CS-19 will also develop different CHW checklists including (a) CHW Pre and Post Training ARI/CDD Tests; (b) CHW Observation Checklist (to be used by CS-19 MCH promoters once in three months) and (c) CHW Client Interview Checklist. CS-19 MCH Promoters will use pre and post ARI/CDD tests to assess the knowledge gained by CHWs, and once every three months will visit selected CHWs to review records and supplies, discuss cases, and interview CHW clients to identify problems and arrange further training. Case management skills will be assessed during review meetings/trainings at facilities. The CHW client interviews will focus on: (a) home care, including completion of prescribed medication; (b) increased fluid intake/breastfeeding; (c) danger signs; and (d) when to return to health workers for a follow-up session.

#### BCC:

In the third quarter of the first year of CS-19, project staff will use the information from KPC surveys, health facility assessments, focus group discussions, and breastfeeding research to develop appropriate BCC activities and health education messages. A checklist will be developed to ensure that the health education materials reflect messages related to project indicators.

CS-19 project staff will assist NGOs participating in PD/Hearth with technical assistance in household registration (if needed), and monitoring and evaluation according to existing guidelines

CS-19 Afghanistan: *Provincial Strengthening*. DIP Draft. Save the Children, April 2004.

from SC and other sources. Hearth Program Managers will use supervisory checklists to monitor the education sessions during Hearth, and will weigh children at entry into the program, at the end of the two-week Hearth session, and at regular intervals for follow-up in the home (suggested intervals are at one month, 2 months, 6 months, and 1 year.) Children who do not recover according to Hearth Program guidelines will be referred to the BHC, and will be closely followed by the CHW. Hearth-attending children will be followed through the regular EPI and GMP programs, and will be home-visited by the CHW if absent more than two consecutive months. CS-19 will assist participating NGOs in program quality assessment and potential for scale-up after 1 year of the Hearth Program.

Every three months, as part of their supervisory visits, the Project Officers (ARI/CDD, MNC, EPI, BCC) will use checklists to assess whether health education activities at the facility and community levels are being carried out regularly.

The MCH Promoters will support CHW efforts of community-based health education activities. The CHWs will use a pre-test questionnaire to assess the knowledge of participants/group members prior to health education sessions and then test their knowledge at the end of the sessions again using the post-health education questionnaire. Every six months, using the same post HE questionnaire, MCH Promoters will assess knowledge of randomly selected mothers and decision makers. In one of these visits, MCH Promoters will use a checklist to assess the knowledge of key decision makers (family members) regarding birth planning. Knowledge will also be assessed every six months through using the BASICS Caretakers Exit Interview Checklist. Information collected will be used to improve health education sessions in the future.

How HMIS data will be collected and analyzed, including sources, frequency, and process of data collection; ensuring data quality; and sharing with and use by stakeholders and partners, including community/beneficiaries

Facility staff will collect and use HMIS data on a monthly basis. Achievements in project activities will be displayed using graphs. Facility staff will also request assistance from their project coordinators if needed. In addition, they will collect, compile, and use information on community activities gathered by CHWs and MCH Promoters. The facility staff will then submit the compiled data to the MOH, CS-19, and REACH Project Coordinators. The HMIS data will be entered in a computer software package and analyzed every month. Feedback will be provided to the facilities and CHWs and to provincial and district health management teams within 14 days of receiving the data. Every three months, CS-19 staff will facilitate the PHO holding a quarterly project planning meeting with the health facility staff, to plan for the following quarter. At the provincial level, the HMIS team, consisting of the PHO HMIS Officer, CS-19 Project Officers and Clerk will be responsible for data compilation, analysis, and planning for data utilization. (Please refer to previous sections for additional details regarding supervisory visits.)

Determination of population denominators; and how eligible women, children, and newborns will enter and participate in the program

CS-19 will replicate the MNC register that SC has used in the Andkhoy Cluster to record antenatal clients, deliveries and births, and postnatal clients. CHWs, *mullahs*, and community health committee members will be encouraged to report all births (of registered and non-registered pregnant mothers) in the communities. Birth registration will help provide estimates for immunization and postnatal care. All births recorded will then be tallied with growth monitoring cards and immunization, and other MCH services will be provided.

Malnourished children with WAZ of -2SD and below will be referred to PD/Hearth sessions from the monthly GMP sessions, or from any of the four levels of health facilities.

#### How M&E skills of local staff and partners will be assessed and strengthened

The CS-19 Project Officers and MOH HMIS Officer will develop training plans and provide training to facility-level health staff. The MOH HMIS Officer will also train CHWs on how to use HMIS reporting forms. CS-19 staff will help in the implementation of an effective supervision and monitoring system, which will use several checklists and other tools. CS-19 will also report on the CS-19-specific activities as outlined in this DIP and the work plan. The CS-19 Project Officers will strengthen the health facility staff and MOH counterparts through:

- Conducting joint supervision using checklists.
- Involvement in the assessments of health worker skills regarding sick child management, EPI, MNC, and BCC.
- Training of staff regarding how to assess community activities.
- Involvement in CDQ, CCM, and PD/Hearth.
- Training staff on how to support CHWs and involving them in CHW support and supervision.
- Training staff on how to use HMIS data at the facility-level and how to prepare feedback for community members.
- Involvement of CS-19 staff in SC's program strategic planning and program operational planning sessions.



#### 4. Work Plan (Tables)

**Table 10. CS-19 Results, Indicators, Measurement Methods and Frequencies, Baseline Values and End of Project Targets for Jawzjan Province**

Strategic Objective/ Intermediate Result	#	Indicator	Method	Freq.	Baseline value	EOP Target	Interv
SO: Improved health practices at household level, & increased use of essential MCH services, in Jawzjan Province.	1	Percent of mothers who received at least two TT injections (card-confirmed) before the birth of the youngest child less than 24 months of age.	KPC Survey	3 Times	15%	35%	MNC
	2	Percent of children aged 12-23 months who received BCG, DPT3, OPV3, and measles vaccines before the first birthday (by card.)	KPC	3 Times	4%	35%	EPI
	3	Percent of infants who received DPT-3.	HIS	Monthly	11%	40%	EPI
	4	Percent of children aged 12-23 months who received measles vaccine (by recall.)	KPC	3 Times	12%	40%	EPI
	5	Percent of children aged 0-23 months with illness in the last two weeks were offered more fluids during the illness.	KPC	3 Times	23%	40%	CDD ARI
	6	Percent of children aged 0-23 months with illness in the last two weeks were offered the same or more food during the illness.	KPC	3 Times	26%	40%	CDD ARI
	7	Percent of mothers who usually wash their hands with soap or ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated.	KPC	3 Times	17%	40%	CDD
	8	Percent of children aged 0-23 months with cough and fast/difficult breathing in the last two weeks were taken to a health facility or received antibiotics from an alternative source	KPC	3 Times	39%	60%	ARI
	9	Percent of children aged 0-23 months whose delivery was attended by skilled health personnel.	KPC	3 Times	28%	43%	MNC
	10	Percent of mothers who had at least one postpartum check.	KPC	3 Times	29%	43%	MNC
	11	Percent of infants aged 0-5 months who were fed breast milk only in the last 24 hours.	KPC	3 Times	68%	80%	Nut
	12	Percent of infants aged 6-9 months who received breastmilk and solid foods in the last 24 hours.	KPC	3 Times	33%	50%	Nut

<b>IR-1:</b> Increased household-level <b>knowledge</b> of essential MCH practices in Jawzjan.	13	Percent of mothers able to report at least two known maternal danger signs during the postpartum period.	KPC	3 Times	29%	50%	MNC
	14	Percent of mothers of children aged 0-23 months who know at least 2 signs of childhood illness that indicate the need for treatment.	KPC	3 Times	14%	30%	ARI CDD
<b>IR-2:</b> Increased <b>access</b> to essential MCH services in Jawzjan.	15	Percent of MOH facilities with female health workers.	CS-19 records	Every Year	43%	90%	MNC
	16	Percent of MOH facilities with 1 or more stock-out of ORS or essential drugs last month (HFA #28).	HFA & Superv.	4X per year	Not available	10%	CDD ARI
	17	CCM successfully piloted, feasibility documented, and quality & use of CHW CCM services documented.	Final Eval.	Once	No	Yes	CDD ARI
<b>IR-3:</b> Increased <b>quality</b> of essential MCH services in Jawzjan.	18	Percent of caretakers of <5's receiving oral drugs know how to administer all essential drugs at home (BASICS HFA indicator #25).	HFA & Superv.	4X per year	26%	50%	CDD ARI
	19	Percent of caretakers of <5's know at least 2 aspects of home care (HFA #26.)	HFA & Superv.	4X per year	59%	70%	CDD ARI
	20	Percent of caretakers of <5's know at least 2 signs of when to return if child gets worse (HFA #27.)	HFA & Superv.	4X per year	66%	80%	CDD ARI
	21	Percent of severely ill <5's classified correctly in MOH facilities (HFA #14)	HFA	3 Times	0%	50%	CDD ARI
	22	CDQ successfully piloted, feasibility and change in service use documented, community perceptions used by facilities to improve quality.	Final Eval.	Once	No	Yes	All
	23	Percent of <5 ARI cases treated correctly in MOH facilities (clinical validation during survey.)	HFA	3 Times	30%	60%	ARI
	24	Percent of <5 diarrhea cases treated correctly in MOH facilities (clinical validation during survey).	HFA	3 Times	35%	60%	CDD

<b>IR-4:</b> Established <b>social network</b> to support key behaviors.	25	Percent of mothers receiving general information or advice on health or nutrition from a member of the informal community network. <sup>51</sup>	KPC	3 Times	1%	30%	ALL
	26	Percent of CDQ Quality Improvement Committees including at least one female participant.	Final Eval.	Once	N/A	40%	All

---

<sup>51</sup> From KPC+2000, the informal network consists of the following: husband/partner, mother/mother-in-law, sister, grandparent, aunt, friend/neighbor, traditional healer, village elder, or other.  
CS-19 Afghanistan: *Provincial Strengthening*. DIP Draft. Save the Children, April 2004.

#### 4. Work Plan (Tables)

**Table 11. CS-19 Results, Indicators, Measurement Methods and Frequencies, Baseline Values and End of Project Targets for *the Andkhoy Cluster***

Strategic Objective/ Intermediate Result	#	Indicator	Method	Freq.	Baseline value	EOP Target	Interv
<b>SO: Improved health practices at household level, &amp; increased use of essential MCH services, in Jawzjan Province.</b>	1	Percent of mothers who received at least two TT injections (card-confirmed) before the birth of the youngest child less than 24 months of age.	KPC Survey	3 Times	79%	90%	MNC
	2	Percent of children aged 12-23 months who received BCG, DPT3, OPV3, and measles vaccines before the first birthday (by card.)	KPC	3 Times	64%	80%	EPI
	3	Percent of infants who received DPT-3.	HIS	Monthly	24%	40%	EPI
	4	Percent of children aged 12-23 months who received measles vaccine (by recall.)	KPC	3 Times	72%	90%	EPI
	5	Percent of children aged 0-23 months with illness in the last two weeks were offered more fluids during the illness.	KPC	3 Times	20%	40%	CDD ARI
	6	Percent of children aged 0-23 months with illness in the last two weeks were offered the same or more food during the illness.	KPC	3 Times	27%	40%	CDD ARI
	7	Percent of mothers who usually wash their hands with soap or ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated.	KPC	3 Times	69%	90%	CDD
	8	Percent of children aged 0-23 months with cough and fast/difficult breathing in the last two weeks were taken to a health facility or received antibiotics from an alternative source	KPC	3 Times	84%	90%	ARI
	9	Percent of children aged 0-23 months whose delivery was attended by skilled health personnel.	KPC	3 Times	13%	43%	MNC
	10	Percent of mothers who had at least one postpartum check.	KPC	3 Times	82%	90%	MNC
	11	Percent of infants aged 0-5 months who were fed breast milk only in the last 24 hours.	KPC	3 Times	66%	80%	Nut
	12	Percent of infants aged 6-9 months who received breastmilk and solid foods in the last 24 hours.	KPC	3 Times	Not available	50%	Nut

<b>IR-1:</b> Increased household-level <b>knowledge</b> of essential MCH practices in Jawzjan.	13	Percent of mothers able to report at least two known maternal danger signs during the postpartum period.	KPC	3 Times	70%	90%	MNC
	14	Percent of mothers of children aged 0-23 months who know at least 2 signs of childhood illness that indicate the need for treatment.	KPC	3 Times	69%	90%	ARI CDD
<b>IR-2:</b> Increased <b>access</b> to essential MCH services in Jawzjan.	15	Percent of MOH facilities with female health workers.	CS-19 records	Every Year	75%	100%	MNC
	16	Percent of MOH facilities with 1 or more stock-out of ORS or essential drugs last month (HFA #28).	HFA & Superv.	4X per year	100%	10%	CDD ARI
	17	CCM successfully piloted, feasibility documented, and quality & use of CHW CCM services documented.	Final Eval.	Once	No	Yes	CDD ARI
<b>IR-3:</b> Increased <b>quality</b> of essential MCH services in Jawzjan.	18	Percent of caretakers of <5's receiving oral drugs know how to administer all essential drugs at home (BASICS HFA indicator #25).	HFA & Superv.	4X per year	67%	80%	CDD ARI
	19	Percent of caretakers of <5's know at least 2 aspects of home care (HFA #26.)	HFA & Superv.	4X per year	87%	90%	CDD ARI
	20	Percent of caretakers of <5's know at least 2 signs of when to return if child gets worse (HFA #27.)	HFA & Superv.	4X per year	96%	Same	CDD ARI
	21	Percent of severely ill <5's classified correctly in MOH facilities (HFA #14)	HFA	3 Times	50%	80%	CDD ARI
	22	CDQ successfully piloted, feasibility and change in service use documented, community perceptions used by facilities to improve quality.	Final Eval.	Once	No	Yes	All
	23	Percent of <5 ARI cases treated correctly in MOH facilities (clinical validation during survey.)	HFA	3 Times	50%	80%	ARI
	24	Percent of <5 diarrhea cases treated correctly in MOH facilities (clinical validation during survey).	HFA	3 Times	60%	80%	CDD

<b>IR-4:</b> Established <b>social network</b> to support key behaviors.	25	Percent of mothers receiving general information or advice on health or nutrition from a member of the informal community network. <sup>52</sup>	KPC	3 Times	Not Available	30%	ALL
	26	Percent of CDQ Quality Improvement Committees including at least one female participant.	Final Eval.	Once	N/A	40%	All

---

<sup>52</sup> From KPC+2000, the informal network consists of the following: husband/partner, mother/mother-in-law, sister, grandparent, aunt, friend/neighbor, traditional healer, village elder, or other.

**Table 12. CS-19 Work Plan of Activities by Intervention**

EPI (20%)																					
Indicator 2. % of 12-23 month olds who received BCG, DPT3, OPV3, and measles vaccines before the first birthday (card.)																					
Indicator 3. % of infants who received DPT3.																					
Indicator 4. % of 12-23 month olds who received the measles vaccine (recall.)																					
Major Activities	Y1 Q3	Y1 Q4	Y2 Q1	Y2 Q2	Y2 Q3	Y2 Q4	Y3 Q1	Y3 Q2	Y3 Q3	Y3 Q4	Y4 Q1	Y4 Q2	Y4 Q3	Y4 Q4	Y5 Q1	Y5 Q2	Y5 Q3	Y5 Q4	Personnel	Benchmark/ Target	Activity Focus*
EPI Management Training for PHO (including sections on HMIS, M &E, keeping registers/log books, and community mobilization)		x																	SC technical staff, MOH physician trainers	20 participants, incl. PHO EPI and HMIS Officers, heads of BHCS, CHCs, and DH, NGO tech staff	Q, BC, A
EPI refresher training						x			x										Same as above	25 participants, same as above incl. HF staff	Q, BC, A
Support MOH in NIDs			x				x				x				x				CS-19 EPI Officer	PHCC NID Committee	Q,A
Development of IEC tools		x		x		x				x				x					CS-19 BCC Officer with PHCC BCC staff	IEC materials developed and displayed in HF	BC
Microplans for poor access areas			x				x				x				x				CS-19 EPI Officer, PHCC	Microplans in place, sites selected	Q,A

Immunization coverage data collection (support to PHO)			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	CS-19 EPI Officer with PHO	CHWs, HF's	Q,A
Feedback on immunization coverage to PHCC				x		x		x		x		x		x		x		x	CS-19 staff, PHO EPI Officer	PHCC	Q
“On the spot” technical support to PHO technical officers		x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	CS-19 EPI Officer	PHO	Q



CDD (15%)																					
<b>Indicator 5.</b> % of 12-23 month olds with illness in the last two weeks who were offered more fluids during the illness.																					
<b>Indicator 6.</b> % of 12-23 month olds with illness in the last two weeks who were offered the same or more food during the illness.																					
<b>Indicator 7.</b> % of mothers who usually wash their hands with soap or ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated.																					
<b>Indicator 14.</b> % mothers of children aged 0-23 mos. who know at least 2 signs of childhood illness that indicate the need for treatment.																					
<b>Indicator 16.</b> % of MOH facilities with 1 or more stock-out of ORS or essential drugs last month.																					
<b>Indicator 17.</b> CCM successfully piloted, feasibility documented, and quality and use of CHW CCM services documented.																					
<b>Indicator 18.</b> % of caretakers of <5s receiving oral drugs know how to administer all essential drugs at home.																					
<b>Indicator 19.</b> % of caretakers of <5s know at least 2 aspects of home care.																					
<b>Indicator 20.</b> % of caretakers of <5s know at least 2 signs of when to return if child gets worse.																					
<b>Indicator 21.</b> % of severely ill <5s classified correctly in MOH facilities.																					
<b>Indicator 24.</b> % of <5 diarrhea cases treated correctly in MOH facilities.																					
Major Activities	Y1 Q3	Y1 Q4	Y2 Q1	Y2 Q2	Y2 Q3	Y2 Q4	Y3 Q1	Y3 Q2	Y3 Q3	Y3 Q4	Y4 Q1	Y4 Q2	Y4 Q3	Y4 Q4	Y5 Q1	Y5 Q2	Y5 Q3	Y5 Q4	Personnel	Benchmark/ Target	Activity Focus
ARI/CDD case management training		x																	SC staff, MOH physician trainers	40 PHO, REACH NGOs, providers	Q
ARI/CDD refresher training						x													SC staff, MOH physician trainers	40 PHO, REACH NGOs, providers	Q
Development and implementation of checklists			x		x		x		x		x		x		x		x		SC staff	implemented at HF	Q,A
MCH promoters work with CHWs		x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	MCH promoters	MOH- selected CHWs	Q,A,BC

CCM Training				x															SC staff	40 participants: MOH, PHCC, selected providers in pilot sites	Q
CCM start-up					x				x					x					SC staff, providers in pilot areas	CHWs	Q
CCM assessed and documented																			CS-19 staff, NGO partners	Preliminary data	Q
CCM refresher training									x										SC staff	80 participants	Q
Development of CDD training modules			x	x															CS-19 CDD/ARI Officer with UNICEF	Modules distributed and used in training	Q,A,BC
“On the spot” technical support to PHO technical officers		x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	CS-19 CDD/ARI Officer	PHO IMCI Officer	Q

ARI (20%)																					
<b>Indicator 5.</b> % of 12-23 month olds with illness in the last two weeks who were offered more fluids during the illness.																					
<b>Indicator 6.</b> % of 12-23 month olds with illness in the last two weeks who were offered the same or more food during the illness.																					
<b>Indicator 8.</b> % of children 0-23 months with cough and fast/difficult breathing in the last two weeks were taken to a health facility or received antibiotics from an alternative source.																					
<b>Indicator 14.</b> % mothers of children aged 0-23 mos. who know at least 2 signs of childhood illness that indicate the need for treatment.																					
<b>Indicator 16.</b> % of MOH facilities with 1 or more stock-out of ORS or essential drugs last month.																					
<b>Indicator 17.</b> CCM successfully piloted, feasibility documented, and quality and use of CHW CCM services documented.																					
<b>Indicator 18.</b> % of caretakers of <5s receiving oral drugs know how to administer all essential drugs at home.																					
<b>Indicator 19.</b> % of caretakers of <5s know at least 2 aspects of home care.																					
<b>Indicator 20.</b> % of caretakers of <5s know at least 2 signs of when to return if child gets worse.																					
<b>Indicator 21.</b> % of severely ill <5s classified correctly in MOH facilities.																					
<b>Indicator 23.</b> % of <5 ARI cases treated correctly in MOH facilities.																					
Major Activities	Y1 Q3	Y1 Q4	Y2 Q1	Y2 Q2	Y2 Q3	Y2 Q4	Y3 Q1	Y3 Q2	Y3 Q3	Y3 Q4	Y4 Q1	Y4 Q2	Y4 Q3	Y4 Q4	Y5 Q1	Y5 Q2	Y5 Q3	Y5 Q4	Personnel	Benchmark/ Target	Activity Focus
ARI/CDD case management training		x																	SC staff, MOH physician trainers	40 PHO, REACH NGOs, providers	Q
ARI/CDD refresher training						x													SC staff, MOH physician trainers	40 PHO, REACH NGOs, providers	Q
Development and implementation of checklists			x		x		x		x		x		x		x		x		SC staff	implemented at HF	Q,A
MCH promoters work with CHWs		x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	MCH promoters	MOH- selected CHWs	Q,A,BC

CCM Training				x															SC staff	40 participants: MOH, PHCC, selected providers in pilot sites	Q
CCM start-up					x				x					x					SC staff, providers in pilot areas	CHWs	Q
CCM assessed and documented																			CS-19 staff, NGO partners	Preliminary data	Q
CCM refresher trainings									x										SC staff	80 participants	Q
Development of ARI training modules			x	x															CS-19 CDD/ARI Officer with UNICEF	Modules distributed and used in training	Q,A,BC
“On the spot” technical support to PHO technical officers		x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	CS-19 CDD/ARI Officer	PHO IMCI Officer	Q

Nutrition (15%)																					
Indicator 11. % of infants 0-5 months who were fed breast milk only in the last 24 hours.																					
Indicator 12. % of infants 6-9 months who received breast milk and solid foods in the last 24 hours.																					
	Y1 Q3	Y1 Q4	Y2 Q1	Y2 Q2	Y2 Q3	Y2 Q4	Y3 Q1	Y3 Q2	Y3 Q3	Y3 Q4	Y4 Q1	Y4 Q2	Y4 Q3	Y4 Q4	Y5 Q1	Y5 Q2	Y5 Q3	Y5 Q4	Personnel	Benchmark/ Target	Activity Focus
Development of IEC materials on nutrition and growth		x	x	x															CS-19 BC Officer with NGOs	Materials available in HFs	BC
GMP technical support				x			x		x			x		x					SC staff	PHO Nutrition Officer	Q
Logistics support for iodized salt distribution			x				x				x				x				CS-19 staff, PHCC, UNICEF	Shopkeepers carry iodized salt	A, BC
Development of BCC messages surrounding iodized salt, breastfeeding and weaning foods			x	x	x														CS-19 BCC Officer, PHCC, UNICEF	Individuals, communities, CHWs	BC
Community mobilization technical support			x				x				x				x				SC staff	PHO	Q, A, BC
PD/Hearth training				x								x							SC staff	PHO, NGOs, PHCC	BC
PD/Hearth technical support, including M & E					x		x		x					x					SC staff	PHO, NGOs, PHCC	Q

MNC (30%)																					
<b>Indicator 1.</b> % of mothers who received at least two TT injections (card-confirmed) before the birth of the youngest child less than 24 months old.																					
<b>Indicator 9.</b> % of 0-23 month olds whose delivery was attended by skilled health personnel.																					
<b>Indicator 10.</b> % of mothers who had at least one postpartum check.																					
<b>Indicator 13.</b> % of mothers able to report at least two known maternal danger signs during the postpartum period.																					
<b>Indicator 15.</b> % of MOH facilities with female health workers.																					
Major Activities	Y1 Q3	Y1 Q4	Y2 Q1	Y2 Q2	Y2 Q3	Y2 Q4	Y3 Q1	Y3 Q2	Y3 Q3	Y3 Q4	Y4 Q1	Y4 Q2	Y4 Q3	Y4 Q4	Y5 Q1	Y5 Q2	Y5 Q3	Y5 Q4	Personnel	Benchmark/ Target	Activity Focus
MNC Training		x																	SC staff, MOH physician trainers	40 participants: PHO, NGOs, PHCC	Q
MNC Refresher							x												Same	Same	Q
Community Midwife Training		x	x	x	x														SC staff, MOH trainers	40 pre- selected female candidates	Q
Community Midwife Refresher							x												Same	Same	Q
Development of BCC messages			x	x															CS-19 staff, NGOs	Use of mass media, print messages in HF	BC
Collaboration with REACH on recruiting female health workers	x	x	x	x	x	x													CS-19 staff	All facilities have female health workers	Q, A
Technical support on community mobilization			x				x				x				x				SC staff	PHO, NGOs	Q, A, BC

Technical support on midwifery			x		x			x		x									SC staff	PHO, NGOs, PHCC	Q
Collaboration as needed on FP activities in BPHS			x				x				x					x			CS-19 RH Officer, REACH staff	FP providers	Q,A, BC
Development of supervisory checklists and quarterly monitoring	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	CS-19 RH Officer	Checklists in use in all districts	Q,A

All interventions																					
Indicator 22. CDQ successfully piloted, feasibility and change in service use documented, community perceptions used by HF to improve quality.																					
Indicator 25. % of mothers receiving general information or advice on health or nutrition from a member of the informal community network.																					
Indicator 26. % of CDQ Quality Improvement Committees including at least one female participant.																					
Major Activities	Y1 Q3	Y1 Q4	Y2 Q1	Y2 Q2	Y2 Q3	Y2 Q4	Y3 Q1	Y3 Q2	Y3 Q3	Y3 Q4	Y4 Q1	Y4 Q2	Y4 Q3	Y4 Q4	Y5 Q1	Y5 Q2	Y5 Q3	Y5 Q4	Personnel	Benchmark/ Target	Activity Focus
Attend PHCC monthly meetings	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	CS-19 Coord.	CS-19 representation in each mtg	
Reporting of baselines to NGOs and MOH	x	x																	CS-19 Coord.		
Completion of Gap Analysis		x																	SC staff	Report	
Completion of Qualitative reports	x																		SC staff	Report	
Development of CDQ implementation with MSH/REACH		x	x	x															CS-19 staff with MSH/REA CH staff	Work plan in place with selected sites	Q,A
CDQ training				x								x							CS-19 staff with MSH/REA CH staff	NGOs interested in piloting CDQ	Q,A,
Equity task force established and action plan development			x		x		x		x		x		x		x		x		PHCC	Action plan created	A
CS-19 Intervention task forces monitoring meetings		x		x		x		x		x		x		x	x				MOH, SC, NGOs, UNICEF	At least 8 meetings with reports	Q,A.BC



BCC messages developed			x	x	x		x				x									CS-19 BCC Officer with PHO counterpart	Community and Mass media messages for all interventions	BC
Transportation provided for health staff at 6 MOH clinics	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	SC staff	MOH facility staff	A
Annual Reports		x				x								x						CS Specialist	3 Annual Reports	Q
Mid Term Evaluation										x										CS Specialist	Midterm Report	Q
Final Evaluation																			x	CS Specialist	Final Report	Q

\*Activity Focus refers to the following: A=Access, BC=Behavior Change, and Q=Quality

## **F. ANNEXES**

- Annex 1. Response to Application Debriefing
- Annex 2. Reports of Baseline Assessments
  - a. KPC Survey Andkhoy
  - b. KPC Survey Jawzjan
  - c. IFHA Report: Andkhoy Cluster
  - d. IHA Report: Jawzjan Province
  - e. Report on Breastfeeding Research
  - f. Focus Group Discussions
  - g. Gap Analysis
- Annex 3. Revised Agreement Between SC and MOH Jawzjan
- Annex 4. DIP Workshop Agenda and Participants
- Annex 5. Map of Afghanistan and the CS-19 Site
- Annex 6. SC CS-19 Afghanistan Revised Organizational Chart
- Annex 7. Diagram of CS-19 and related MOH and REACH counterparts
- Annex 8. Resumes/CVs of Key Personnel (revisions from original application)
  - a. Ms. Kathryn Bolles
  - b. Dr. Honey Mukhtar
  - c.. Ms. Kim Allen
- Annex 9. Rapid CATCH Summary Data
- Annex 10. PHO Terms of Reference
- Annex 11. Supervisory Checklist Sample

## ANNEX 1. RESPONSE TO APPLICATION DEBRIEFING

(Please see the original application review summary score sheet and external reviewer comments inserted at the end of this annex. SC response appear below, in regular font, to weaknesses noted in the summary score sheet, in italics.)

### Budget

*Is there a need for additional radios/satphones/internet for both information sharing and security? Who will pay the costs of running the generator?*

SC will receive five new Codan phones through the REACH grant, and CS-19 will cover the cost of one Thuraya satellite phone. Generator and fuel costs are covered through other funding sources.

*Will translation of materials be needed, and are these costs covered?*

Many materials for trainings mentioned in the application workplan are already in local languages. BCC and IEC materials developed by CS-19 will be developed in the local language/s, and CS-19 will cover 50% of the salary of the SC staff translator.

*Would GPS units be helpful for mapping/tracking beneficiaries, assessments, and supervision?*

SC's Thuraya satellite phones have GPS units built into the phone. GPS technology is being applied to track clinics and mapping in the REACH workplan. CS-19 will participate as needed, but will not be a specific CS-19 activity.

### Executive Summary and Overall Application

*"Continuing SC's efforts to increase the number and quantity of female health workers will be critical to success."*

Recruiting female health workers (professional doctors and nurses in the BHCs, CHCs, and the hospitals as well as female vaccinators and CHWs) is a primary strategy of REACH. Through REACH funding, SC and other NGOs, under the supervision of the MOH, will recruit and train female staff within Jawzjan Province, with particular emphasis on training local women who will represent the geographic and ethnic diversity within the communities. CS-19 will support the recruitment and training of female staff, as requested.

### Description of the PVO Applicant

*"The applicant may have difficulty identifying staff. The applicant needs to interact more closely with central MOH in Kabul. The MOH will be establishing Provincial Coordination Committees which will be a good vehicle for SC to support and strengthen."*

The changes in the CS-19 design reflect a much stronger association with the MOH in Jawzjan Province, with concurrence from the MOH in Kabul. Through REACH, new staff is in place at all facility levels, and CS-19 is in the process of hiring the 4 additional technical officer

positions, set to begin work in May 2004. The CS-19 Coordinator sits on the Executive Committee of the newly-formed Provincial Coordination Committee, which allows SC the opportunity to both support the PCC and play a lead role in decision-making.

### Situational Analysis

*“The applicant could have used the National Health Resource Assessment to clearly describe what health facilities are functioning in Jawzjan.”*

During the DIP planning process, CS-19 staff met with the USAID Mission representative and MSH/REACH staff to discuss the functioning and non-functioning facilities in Jawzjan. A list was under development in March 2004, with plans to improve the quality of existing clinics, rebuild others, and establish new facilities. CS-19 staff additionally met with the Provincial Health Director and agreed to support 6 nonfunctioning clinics that will not be supported through REACH (as discussed in the Strategies section E.2 of the DIP.)

*“SC will need to establish clear lines of communication with USAID REACH contractor to assure synergy with the two projects.”*

CS-19 has met with REACH coordinators in both Kabul and Jawzjan regarding the revisions of the application design, and on several occasions throughout the DIP process. Three MSH/REACH staff attended and contributed to the DIP workshop in March, and CS-19 will remain in close contact with REACH staff throughout the five years, supporting REACH activities and adapting CS-19 to supplement activities and meet training and support needs as BPHS activities progress.

### Program Strategy and Interventions

*“It isn’t clear how SC will achieve the ambitious results without more female health workers.”*

REACH (with SC and other NGOs) will actively recruit female health workers as a first-tier strategy for REACH-funded NGOs, and is listed as the first item in the REACH RFA under Enhancing the Number and Quality of BPHS Services in the following statement:

“Training of new female and male community health workers or updating existing health workers at the community level, with an emphasis on training women...” SC, with REACH funding, will participate in this strategy, and CS-19 will support and offer any needed trainings.

*“SC could provide some innovative approaches...most of what is being presented is fairly traditional...for example, how will SC use/contribute to data to prioritize high risk areas?”*

The network of NGOs in Jawzjan, as well as the MOH, have expressed great interest in the SC innovative approaches: 1. Community Defined Quality- to more equitable access and quality improvement of health services, and 2. Community Case Management. Case management is included in the BPHS document, and REACH-funded NGOs have already indicated interest in information sharing and trainings on CCM. Additionally, with the new CS-19 focus on provincial-level strengthening, CS-19 will have the flexibility to fill in gaps in BPHS activities not yet supported through other funding mechanisms.

Data collection and analysis is key to achieving impact in new BPHS program activities. The SC Senior Health Coordinator and IMCI expert is currently training REACH project managers in LQAS methodology for EPI activities. Throughout the five years, CS-19 will offer refresher trainings on this methodology.

*“How will non-health policy and decision makers be informed about key health status/risk issue and be influenced to make policy change?...Will both the MOH and other related Ministries be engaged?”*

With REACH, and new policies currently under development, SC is already in place as a key participant in planning and collaboration with the government of Afghanistan through REACH, CS-19, and participation in supervisory and policy planning committees like the PHCC. SC’s credible and solid relationship with the MOH and other key policy makers has allowed CS-19 to be an important mechanism to bring about positive change.

*“Will iodine supplementation be included? Why can’t SC secure an adequate supply of vitamin A and other micronutrients?...Can the applicant put less emphasis on EPI...and more on nutrition and FP?”*

In response to requests from the MOH and the PHCC, and corresponding with the opening of a new factory for salt iodization, CS-19 will join UNICEF in supporting the salt distribution to shopkeepers, and the development of BCC messages to communities. Due to a higher than expected percentage of children receiving Vitamin A supplements from the CS-19 baseline, and because other programs in Jawzjan will focus more on Vitamin A, CS-19 has removed this as an intervention. After discussions with the network of NGOs in Jawzjan, CS-19 has reduced the level of effort for EPI from 25% to 20%, and increased that for Nutrition from 5% to 15%, in order to align with REACH priorities and concentrate more on community-based rehabilitation for malnourished children. Family Planning activities has been subsumed into the MNC intervention.

*“The applicant’s ambitious proposal will require perseverance, constant effort and staff mobilization in a fluid post-conflict situation. This may constrain what the project will accomplish.”*

Lawlessness and intermittent conflict continues and has occurred in the CS-19 impact area at the time of the writing of this document, and CS-19 project activities will continue to achieve as much as possible without putting any staff at risk. With the new health policies in place, CS-19 expects to achieve even greater impact through supporting the implementation of the BPHS at the provincial level. This strengthening will build sustainable support for health activities, and will further develop the relationship between SC and key partners in Jawzjan.

*“One concern is the project intends to increase the use of trained midwives...with this small number, it seems unlikely that this part of the project will have the desired effect of reducing maternal and neonatal mortality. ..Trained attendants will not be sufficiently available...”*

Community Midwife training and Midwife training will be covered through REACH funding, and an additional RFA for these was released in March 2004. CS-19 plans to support one MOH Midwife training for 40 pre-selected candidates (who have already signed contracts stipulating

their return to rural communities to practice) for one complete training and a subsequent 4-week refresher training. This doubles the initial number of 20 trained midwives from the original proposal. However, to date no NGO has responded to the recent REACH RFA from Jawzjan; therefore, CS-19 will support additional trainings, if any, for Jawzjan Province and in strict collaboration with REACH. Due to the recent MOH policy rescinding the practice of TBAs, CS-19 will work with the PHCC to immediately develop an action plan for deliveries normally attended by TBAs, and before additional midwives are in place.

### Performance Monitoring and Evaluation

*“The appropriateness of some indicators for IR-3 (#30-33) will depend on the numbers of facilities.”*

This comment refers to the following objectives in the application:

1. 10% of CS-19 supported facilities had 1/more stock-out of ORS or essential drugs last month.
2. 90% of CS-19-supported facilities achieve perfect EPI quality index score.
3. \_\_\_% of CS-19 supported facilities achieving \_\_\_ MNC quality index score.
4. 100% of BHCs have FP-trained female health worker posted & 3 birth spacing methods in stock.

CS-19 has adapted the list of indicators to correspond more appropriately to the new design. IR-3 has changed from “Improved capacity of the Jawzjan MOH to provide quality MCH services” to “Increased quality of essential MCH services.” CS-19 will assist in the development of supervisory checklists (see Annex 11 for an example) and will collaborate with UNICEF, MOH and others to finalize new protocols and quality standards. Indicator 1 listed above will remain in the “quality” IR, and will be measured with the denominator of 27 (22 MOH facilities in Jawzjan supported by CS-19 plus 5 facilities in Andkhoy.<sup>1</sup>) Indicators 2 and 3 will be excluded from CS-19 as written. In the IHFA baseline for Jawzjan, only half of the health facilities had some FP methods in stock, and both use and FP counseling provided by health workers were low (12% and 14%, respectively.) Given that REACH funds will have FP options available at all levels of facilities (not only BHCs as written in indicator 4 above) and that FP activities through REACH will not begin immediately, this indicator will change to “70% of facilities have FP-trained female health workers posted and 3 birth spacing methods in stock.”

*“Some of the EPI antigen indicators may present some problems...it is likely that this indicator would always be under target level at any given point in time.”*

This refers to the following objectives in the application:

1. 60% of infants receive DPT-3.
2. 70% of infants receive measles immunization.

The review summary comments are relevant to these indicators if measured through surveys. The reference to “HIS” as the method for data collection in the indicator table to which this comment refers (Table 2 of the application) signified that the indicators would be measured

---

<sup>1</sup> The number 27 is the closest approximation possible at this time. A new facilities list is under development by the MOH and REACH.

using the administrative method (involving HIS data on antigens given and estimated population denominators). The objectives suit this measurement method, not survey-based methods.

*“For #11 in Table 2 (referring to indicator: Double the number of children <5 treated for pneumonia by CS-19 trained health workers), it would be better to express this as a percent of children with severe respiratory symptoms who were treated for pneumonia. The indicator given is an output indicator...”*

We believe there are advantages to the planned HIS-based approach, which is much less expensive to track over time than survey-based estimates. What is recommended in the review comments (“% of children with severe respiratory symptoms who were treated for pneumonia”) sounds more appropriate for research studies, such as the BOSTID studies in the 1980s involving twice-weekly visits to households. An alternative more feasible approach used in the KPC & DHS surveys involves maternal reporting of children ill in the last two weeks with fast/diff breathing for estimation of the denominator. A disadvantage of this is that estimates require surveys, and BCC activities are likely to increase maternal reporting of ARI Needing Assessment (the denominator.)

*For #12 ( refers to the following indicator: 15% increase in % of children <2 whose births were attended by a skilled health professional), given that the program will train both Auxiliary Nurse-Midwives and TBAs, it would be useful to identify the type of attendant...”*

The MOH no longer supports, and CS-19 no longer has plans for, training TBAs. The term “skilled health professional” refers to either Community Midwives, Midwives, or Doctors, as defined in the BPHS policy document.

The Debriefing Summary Sheet and Application Review Comments are only available in hard copies and are not included in the electronic version of this document.



## ANNEX 2. REPORT OF BASELINE ASSESSMENTS

### A. KPC Survey: Andkhoy Cluster

(Note: This is a working document, and will be finalized by June 30, 2004.)

Dated January 2003

#### Findings:

##### A. General

##### A.1. Distribution of the clusters

Interviews were carried out in 30 clusters located in Andkhoy, Qaramqol, Qorghan and Khan-i-charbagh. Please see table 1 for distribution of clusters throughout Andkhoy and its three neighboring rural districts.

Table 1

Name of areas	Number	Percentage
Andkhoy town	151	50.2%
Khanecharbagh rural district	40	13.3%
Qaramquol rural district	40	13.3%
Qorghan rural district	70	23.3%

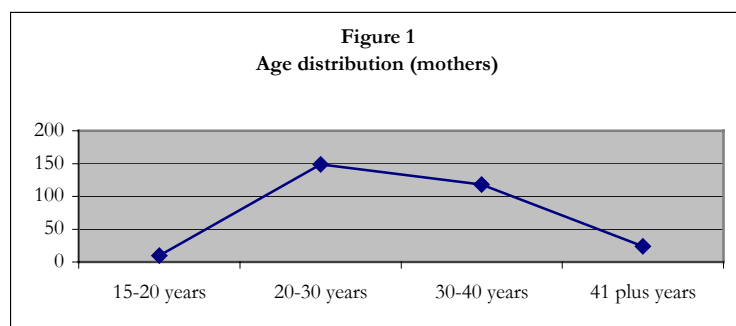
This information was not recorded in this survey, but the results of KPC survey 1999 revealed that Uzbeks make up 63.5% of the population and Turkmans 33%. Pushtuns, Arabs and Tajik are the minority ethnic groups. Returnees did not affect Andkhoy cluster, therefore it can be assumed that the composition of population stays the same.

##### A.2. Husband's occupation

Regarding occupation, 34.9% mothers informed that their husbands were laborers on daily wages, 18.9% were shopkeepers, 15.6% worked in agriculture fields, 11% raised livestock, 10.3% were salaried workers and 7.3% were carpet merchants and 0.3% were mullahs. In addition, 7% mothers also mentioned other sources of income including small side businesses, cobbling, flourmill, and motor mechanic.

##### A.3. Age of the mothers in the survey

The age of the mothers ranged between 17 to 47 years, with mean age at 33 years. Figure 1 presents age-wise distribution of mothers.



##### A.5. Distribution of age and sex of children in the sample

The age of the children in the sample ranged between 0-24 months, with mean age at 10 months. 54.3% children were females and 45.7% males. Table 2 shows further age-wise classification of children in the survey.

**Table 1**

Age groups	Number	Percentage
0 to 5 months	96	32%
6-12 months	78	26%
13-24 months	125	41.6%
Not recorded	1	0.33%

#### **A.6. Mother's education**

Of the mothers surveyed (n=300) 86.4% were illiterate. Eleven percent received primary education (7% could not read and 4.3% could read) and only 2.3% mothers received secondary education.

#### **A.7. Caretakers:**

The main purpose of this question is to determine whether mothers work outside home leaving their children to other caretakers. This information will help deliver health education messages to appropriate caretakers. This survey found that 99% mothers stay at home, only 1% leave their homes to weave carpets leaving their children to grandmothers or with their older siblings.

### **B. Breastfeeding/Nutrition.**

#### **B.1. Breastfeeding Practice**

Of the total (n=300) 98% mothers were breastfeeding their youngest child at the time of this survey. Seventy-six percent mothers mentioned that they put their newborns to breasts within the first hour after the delivery. Fourteen percent mentioned between two to eight hours and 8.4% mentioned more than eight hours after delivery. A few (1%) did not remember.

Time mothers first put babies to their breasts.	Percentage	1999 results <sup>2</sup>
During the first hour after delivery	76.1%	25%
From 2-8 hours after delivery	14.5%	13%
More than eight hours after delivery	8.4%	61%
Do not remember	1%	-

Whether anything else should be given to infants under five months of age in addition to breast-milk, 45.6% mothers (137/300) said no. Twenty-four hour recall revealed that 65.7% (69/106) mothers of children age less than 6 months did not feed anything else and were exclusively breastfeeding in the past 24 hours. Of those who gave something else in addition to breast milk (37/106), 92% gave water, 43.5% gave home-made liquid diet (soup and rice water), 13% gave infant formula milk and 5% gave animal milk.

Twenty four recall ( ≤ 6 months	Percentage	1999
---------------------------------	------------	------

<sup>2</sup> Question asked was "after delivery when did you first initiated breastfeeding"

<b>old –n=106)</b>		<b>results</b>
Only gave breast milk	65.7%	48.4%
Gave in addition to breast milk	34.3%	-
Those who gave (n=37)		
Water	92.3%	26%
Juices	7.69%	-
Infant formula	12.8%	6.4%
Other milk	5.12%	-
Soup/liquid diet	43.5%	23%

Of the total (n=300), 92.3% mothers informed that a child should be breastfed for a period of two years (90% in 1999). A total of 7% mothers were pregnant at the time of this survey and except for one mother all were still breastfeeding their youngest child between the ages of twelve to twenty-four months.

Regarding what should a mother do in the child's first four months to support breastfeeding, 65% (195/300) mothers mentioned initiating breastfeeding as soon as possible after delivery, 46.2% mentioned care of breasts and nipples, 42% mentioned allowing baby to frequently suck breasts to stimulate milk production, 29.9% mentioned exclusive breastfeeding and 19.6% mentioned avoiding bottle feeding. 2% cited relactation (if had to stop, mother can resume breastfeeding). 12.2% did not know.

<b>Practices to produce breast milk</b>	<b>2003 results</b>
Gave at least one answer	87.8%
Did not know	12.2%
1. Initiate breastfeeding soon after delivery	65.1%
2. Care of breasts, nipples	46.2%
3. Frequent sucking to stimulate production	42.0%
4. Exclusive breastfeeding (first four months)	29.9%
5. Avoid bottle feeding	19.6%
6. Relactation	2.0%

## **B.2. Introduction of weaning foods**

Regarding when should a mother first start adding foods in addition to breastfeeding, 54.5% (164/300) mentioned six months, 15.6% mentioned between 4-5 months, 17.3% mentioned earlier than 4 months and 9.3% said later than six months. 3.3% did not know. The table below shows the comparison of the results between 2003 and 1999 KPC survey results.

<b>Time to introduce weaning foods</b>	<b>2003</b>	<b>1999</b>
--	-------------	-------------

	results	results
Earlier than 4 months	17.3%	-
Start at six months	54.5%	32.5%
Start between 4-5 months	15.6%	47.5%
Later than 6 months	9.3%	-
Do not know	3.3%	15%
Others		5%

### **B.3. Knowledge regarding food rich in Vitamin A**

When asked which foods are rich in vitamin A, 75.7% (226/300) mothers knew at least one food source compared to 58% in 1999. Meat/liver was mentioned more frequently (58%) than other sources. 39% mentioned green leafy vegetables, 38% yellow fruit or vegetable types and 33.2% mentioned eggs. 19.3% mothers mentioned breast milk. 12% also mentioned other sources including beans, other fruits, oil/fat, tubers and red raisins.

<b>Foods rich in Vitamin A</b>	<b>2003 results</b>	<b>1999 results</b>
Green leafy veg.	39.2%	32.6%
Yellow fruit/veg. Type	38.0%	42%
Meat/fish	58.1%	46%
Breast milk	19.3%	12%
Eggs/egg yolk	33.2%	45%
Others.....	12%	4%
Knew one source at least	75.7%	-

### **B.4. Vitamin A supplementation**

Of the total mothers with children older than eight months<sup>3</sup> (n=181), 82.9% informed that their children received one high dose of vitamin A (61% in 1999).

### **B.5. Use of iodized salt**

Whether iodized salt is added to the child's food, 69.8% (209/300) mothers said yes, 25.9% said no and 4.3% did not know. This information was not collected in 1999.

### **C. Growth monitoring**

A total of 87% mothers informed that their youngest child was weighed at birth. Of these 97.7% (293/300) showed their child's growth monitoring card. On examining the GM cards, 50% children were weighed at least four times since they were born, 18.9% three times, 14.6% two times and 16.5% once.

### **D. Diarrheal Disease**

Of the total 16.3% (49/300) mothers informed that their child had diarrhea in the past two weeks.

#### **D.1. Breastfeeding, giving fluids and feeding during diarrhea**

How much the mothers gave fluids to their children during the episode of diarrhea, 24.5% mentioned more than usual, 18.4% same as usual and 36.7% less than usual. Twelve percent

<sup>3</sup> National policy is to give high dose of vitamin A to children when they get their measles vaccines at 9 months (100,000 i.u). Higher dose 200,000 i.u is given to children 12 months and older.

informed they completely stopped breastfeeding and 8.2% mentioned they exclusively breastfed the child.

<b>Frequency of breastfeeding during the episode of diarrhea</b>	<b>2003 results (n=49)</b>	<b>1999 results</b>
More than usual	24.5%	44.6%
Same as usual	18.4%	34.8%
Less than usual	36.7%	17.3%
Stopped completely	12.2%	3.3%
Exclusively breastfed	8.2%	-

Regarding how much was the child fed (semi-solid/solid) during the episode of diarrhea, 14.3% mothers mentioned they fed more than usual, 12.2% same as usual and 36.7% less than usual. 10.2% informed that they stopped foods completely. 8.2% mothers did not remember. 18.4% children were exclusively breastfed.

<b>Frequency of giving foods during the episode of diarrhea</b>	<b>2003 results (n=49)</b>	<b>1999 results</b>
More than usual	14.3%	18.5%
Same as usual	12.2%	31.5%
Less than usual	36.7%	27.2%
Stopped completely	10.2%	22.8%
Exclusively breastfed	18.4%	-
Did not remember	8.2%	-

## **D.2. Treatment provided during diarrhea episode**

Regarding treatment that was provided to the child with diarrhea, 91.8% mentioned they gave medicines (pills, injections, syrups), 42.9% mentioned that they gave ORS solution. 30.6% gave herbal homemade remedies. Only 8.2% gave homemade fluids

<b>Treatment provided during the episode of diarrhea (at home)</b>	<b>2003 results (n=49)</b>	<b>1999 results</b>
Gave nothing	8.2%	11%
ORS	42.9%	66%
Home made fluids	8.2%	5%
Pill/syrups/injections	91.8%	74%
Home remedies/herbal	30.6%	25.3%

## **D.3. Seeking care outside home**

Of the total mothers (n=49), 73.5% mentioned that they sought care outside home, 12.2% informed that they bought medicines on their own. Multiple sources for seeking health care were mentioned. These included: private practitioners (41.5%), traditional birth attendants (29.3%), district hospital (25%), mullahs and other traditional healers (24.4%), BHC/health centers (17.1%) and 9.8% from village health workers (female CHWs). 4.9% sought help from relatives and friends.

Sources of treatment	2003 results (n=49)
Hospital	25%
Health center/BHC	17.1%
Private doctor	41.5%
Village health worker	9.8%
Traditional healer	24.4%
Traditional birth attendant	29.3%
Relatives and friends	4.9%

#### **D.4. Decision makers**

Regarding who made the decision to seek care outside home for the child with diarrhea mothers mentioned more than one decision makers. These included grandmother 39%, father 34% and friends 4.9%. In 24.4% cases, mothers herself decided to seek care outside.

#### **D.5. Knowledge of danger signs among children with diarrhea**

Regarding danger signs in children with diarrhea, 59.5% mothers mentioned fever, 36.2% cited prolonged diarrhea, 31.9% mentioned loss of appetite/vomiting, 26.2% weakness/tiredness/lethargy, 23.6% mentioned dry mouth, sunken eyes and decreased urine output and 20.6% cited blood in the stool. 9.6% mothers did not know. In sum, 51.1% mothers knew two danger signs and 31.3% knew three.

Knowledge regarding danger signs	2003 results (n=300)	1999 results (n=300)
Do not know	9.6%	7%
Loss of appetite/vomiting	31.9%	67.8%
Fever	59.5%	61%
Dry mouth/sunken eyes/decreased urine	23.6%	15%
Prolonged diarrhea	36.2%	23.7%
Blood in the stool	20.6%	20.9%
Weakness/tiredness	26.2%	37.4%
Knows 1 danger signs	17.6%	
Knows 2 danger signs	51.1%	
Knows 3 or more danger signs	31.3%	

#### **D.6. Knowledge regarding diarrhea prevention**

Regarding preventive measures against diarrhea, 55% mothers mentioned washing hands after using latrines, 38% mentioned feeding freshly prepared food, 33% mentioned washing hands before preparing food, 29% mentioned washing hands before feeding the child. 6.3% mentioned measles vaccines prevent diarrhea. Twenty-two percent mothers did not know.

<b>Knowledge regarding preventive measures</b>	<b>2003 results (n=300)</b>	<b>1999 results</b>
Ex. Breastfeeding	14.3%	16%
Washing hands/latrines	55.1%	51%
Washing hands before preparing food	32.9%	47.9%
Washing hands before/feeding	28.9%	38.5%
Feeding freshly made food	38.2%	14.9%
Measles vaccine	6.3%	0.9%
Do not know	21.6%	21.3%

#### **D.7. Knowledge regarding ORS preparation**

Eighty percent (240/300) mothers informed that they know how to prepare ORS. Of these 73.3% demonstrated correct preparation of ORS.

<b>Knowledge regarding ORS preparation</b>	<b>2003 results</b>	<b>1999 results</b>
Informed they know ORS preparation (n=300)	80%	75%
Demonstrated correct ORS preparation (n=240)	73.3%	92%

#### **E. Acute Respiratory Infections (ARI)**

A total of 31.2% (94/300) children under two years enrolled in this survey had an episode of cough/difficult breathing in the past two weeks. Of these, 91.5% had cough, 73.4% also had fast breathing, 10.6% had chest in drawing and 24.5% had difficult breathing.

##### **E.1. Seeking care for children with cough/difficult breathing**

Of the total children who were sick (n=94), for 83.9% care was sought outside home. Care was sought from one or more sources such as private practitioners (48.8%), hospital (27.5%), traditional healers/mullahs (27.5%), traditional birth attendants (25%). 15% mothers also mentioned FHSs and FHWs and 11.3% BHCs. Friends and relatives were contacted for advice in 11.3% cases. Eleven percent mothers mentioned that they bought the medicines and treated their sick child themselves.

<b>Sources of health care seeking</b>	<b>Percentage (n=94)</b>
Hospital	27.5%
Health center/BHC	11.3%
Private doctor	48.8%
FHSs/FHWs	15%
Traditional healer	27.5%
Traditional birth attendant	25%
Relatives and friends	11.3%
Bought medicine (self treatment)	11.3%

### **E.2. Knowledge of danger signs in children with cough**

Of the total (n=300), 81% mothers mentioned fast breathing as a danger sign in a child with cough and 35.9% mentioned chest indrawing. Sixty-nine percent knew two or more danger signs.

<b>Knowledge regarding danger signs (ARI)</b>	<b>2003 results</b>	<b>1999 results</b>
Do not know	2.7%	7.6%
Fast breathing	81.1%	39.8%
Chest in drawing	35.9%	35%
Others	4.3%	34%
Knows one danger sign	26.9%	
Knows two danger signs	44.9%	
Knows three or more danger signs	24.5%	
Do not know	3.7%	

### **E.3. Knowledge - Home Care for a child with cough/difficult breathing**

Regarding home care for children with cough/difficult breathing, 42% (126/300) mothers mentioned to continue breastfeeding, 25.6% mentioned to continue medication as prescribed, 17.6% mentioned to increase fluid intake, 15% mentioned to give prescribed medicines and 10.6% mentioned increasing food intake.

<b>Home care rules (ARI)</b>	<b>2003 results</b>	<b>1999 results</b>
Continue breastfeeding	42.2%	21%
Increase fluids	17.6%	27.9%
Increase nutritious food/feed	10.6%	16%
Continue medication as prescribed	15%	28.9%
Look for danger signs	25.6%	0.9%
Knows one	35%	
Knows two rules	31.5%	
Knows three or more	23.6%	
Do not know	9.9%	

## **F. Immunization:**

### **F.1. Childhood immunization**

Of the total 91.4% (274/300) mothers informed their children less than two years of age (enrolled in this survey) received vaccines. Ninety-six percent mothers showed the child's immunization card as compared to only 69% in 1999. Less cards are lost (1.5%) as compared to 1999 (17.6%) and very few reported that they never received any EPI cards.

<b>Immunization Cards</b>	<b>2003 results</b>	<b>1999 results</b>
Cards present and shown to surveyors	96%	69%
Reported that cards were lost	1.5%	17.6%
Never received any cards	2.5%	13.3%



## **F.2. Child immunization Coverage**

Overall BCG coverage among children 0-23 months is 86.6%, which shows that the project staff's access to eligible children is very good. The results for immunization are presented for two age groups: 0-11 months and 12-24 months:

BCG coverage is 80% among a total of 155 children between 0-11 months of age. Results from the card examination show: OPV1 58.7%, OPV2 37.4%, OPV3 29%, DPT1 56.1%, DPT2 32.2% and DPT3 23.8%. Very high dropout rates are noted between OPV1 and OPV3 (50.5%) and between DPT1 and DPT2 (57.4%), indicating poor follow-up to provide additional doses to complete vaccination schedule. WHO recommends that drop rate 10% or more should call for a community based rigorous EPI-follow-up activities.

WHO recommends that a child must be fully immunized<sup>4</sup> by his/her first birthday – the survey team examined EPI/immunization cards to assess the immunization status among children between ages 12 to 23 months. The results show encouraging achievements: BCG 93.5%, measles 72.2%, OPV3 85%, and DPT3 80%. Sixty-four percent children 11-24 months are fully immunized. However, an overall drop out rate at 22.7%<sup>5</sup> points towards the need of follow-up by additional doses.

<b>Coverage of each antigen (11-23mo) n=155</b>	<b>2003 results n=155</b>	<b>1999 results n=105</b>
BCG	93.5%	50.4%
OPV1	90.3%	51.4%
OPV2	87.7%	37%
OPV3	85.1%	24%
DPT1	87%	51.4%
DPT2	83.8%	35%
DPT3	80%	22%
Measles	72.2%	39%

NIDS coverage is at 77.9%

## **F.3. Reasons for not vaccinating their children**

Among those children who were not vaccinated reasons were asked. 38.5% mothers did not know why their children were not vaccinated. 30.8% informed that vaccines were available and 23% gave reasons indicating that they had been misinformed.

<b>Reasons for not vaccinating children n=26</b>	<b>2003 results</b>
Does not know	38.5%
Not aware of vaccine's importance	3.8%
Not aware of the time to start vaccination	3.8%
Vaccine not available	30.8%
Misinformation regarding vaccines	23%

<sup>4</sup> Fully immunization coverage includes BCG, OPV1, 2 & 3, DPT 1, 2 & 3 and measles.

<sup>5</sup> Drop Out rate is calculated as:  $\frac{\text{Total BCG} - \text{total Measles}}{\text{Total BCG}} \times 100$

#### **F.4. Mother's knowledge regarding immunization**

Regarding how many times should a child receive vaccines to complete his/her immunization schedule, 84.7% (254/300) mothers mentioned five times, 11.9% mentioned more than five times and 3.4% did not know.

#### **F.5. TT vaccination coverage**

Of the total mothers (n=300), 92.7% mentioned that they received an injection (TT vaccine) in their arm and of these 89.3% showed their own vaccine card. Examining the TT vaccination card the immunization status of mothers was assessed. The results showed: TT1 100%, TT2 95.6%, TT3 84.4%, TT4 36% and TT5 11.6%. Overall TT2 coverage in Andkhoy cluster among pregnant women is 79.4%<sup>6</sup> as opposed to 45% in 1999.

<b>TT2 coverage per EPI cards</b>	<b>2003 results</b>	<b>1999 results</b>
TT1	100%	28.5%
TT2	95.6%	45.8%
TT3	84.4%	25.5%
TT4	36%	-
TT5	11.6%	-

#### **F.6. Reasons for not taking TT vaccine**

Mothers who mentioned that they never took TT vaccine, 28.6% mentioned that they are not aware of the time to start getting TT vaccine, 28.6% mentioned that vaccines were not available, 14.3% were not aware of TT vaccine's importance and 19% did give any reasons.

<b>Reasons for taking TT vaccine (n=21)</b>	<b>2003 results</b>	<b>1999 results</b>
Does not know	19%	14.3%
Not aware of vaccine's importance	14.3%	14.3%
Not aware of the time to start vaccination	28.6%	33.3%
Vaccine not available	28.6%	7%
Misinformation regarding vaccines	9.5%	2.4%

#### **Knowledge of mothers regarding TT vaccine**

Of the total mothers 52.4% mentioned that TT vaccine protects both the mother and the newborn, 14.3% said it protects only mother, and 9.5% mentioned it protects only the newborn. 23.8% mothers did not know.

<b>Why TT is important</b>	<b>2003 results</b>	<b>1999 results</b>
Protect both mother/newborn	52.4%	24%
Protect only mother	14.3%	44%
Protect only newborn	9.5%	10%
Do not know	23.8%	21.3%

<sup>6</sup> Total mothers with TT2 divided by 300 mothers in the survey sample x 100

## G. Maternal Health

### G.1. Antenatal Care:

Of the total, 89.3% (268/300) mothers informed that they sought antenatal care. Those who did not attend (n=32), 40.6% mentioned that the BHC is too far, 25% were not aware of its importance, 12.5% were not allowed by the family members and 3.1% mentioned that they staff at the BHC was not available. 18.8% gave other reasons.

Reasons for not attending ANC sessions	2003 results	1999 results
Distance too far	40.6%	35%
Not aware of its importance	25%	36%
Were not allowed by family members	12.5%	12%
Went but staff not available	3.1%	1%
Other reasons	18.8%	16%

Of those who attended ANC sessions, 96.3% (258/268) went to MOH MCH/BHCs and 1% went to private practitioners and 2% to FHWs and TBAs.

Sources for ANC sessions	2003 results	1999 results
MOH BHC/MCH clinics	96.3%	80%
Private doctors	1.1%	8%
TBA/FHWs	1.9%	11.3
Others	0.7%	

Seventy percent (187/268) mothers mentioned that they attended antenatal care sessions three or more times, 16.4% two times and 13.7% for only once.

Number of times attending ANC session	2003 results	1999 results
Once	13.7%	20.6%
Two times	16.4%	28.9%
Three or more times	69.8%	50.5%

Of those who attended antenatal care sessions, 86.6% (232/268) showed their antenatal cards. 6.7% mentioned they never had one and another 6.7% said they lost it. The cards revealed that 69.1% mothers had attended the antenatal clinics three or more times. The cards also showed 70.7% mothers received iron tablets (54% in 1999).

#### **G.1.1. Knowledge of mothers regarding antenatal care**

Regarding when should a pregnant mother first attend antenatal clinic, 24.6% mothers mentioned first trimester (24.6%) and 57.5% second trimester. A total of 82.1% mothers (compared to 66.5% in 1999) mentioned that they first attended antenatal clinic during the first and second trimester. Only 7.6% mothers didn't know as compared to 24% in 1999.

<b>When should pregnant women first attend ANC session</b>	<b>2003 results (n=300)</b>	<b>1999 results</b>
First trimester	24.6%	40%
Second trimester (4-6 months)	57.5%	26.5%
Last trimester	9%	7.6%
No need to see the health worker	1.3%	2%
Does not know	7.6%	24%

### **G.1.2. Knowledge regarding nutrition during pregnancy**

Regarding how much should a pregnant woman eat, 33.2% mentioned more than usual, 33.2% same as usual, 32.9% less than usual and 0.7% didn't know.

<b>How much a pregnant woman eat</b>	<b>2003 results (n=300)</b>	<b>1999 results</b>
More than usual	33.2%	19%
Same as usual	33.2%	31%
Less than usual	32.9%	48%
Said they didn't know	0.7%	2%

Regarding which foods prevent anemia in a pregnant woman, 77.1% mothers mentioned protein source such as meat, liver and eggs and 57.1% mentioned green leafy vegetables. 13% mothers mentioned they did not know.

<b>Foods that prevent anemia</b>	<b>2003 results (n=300)</b>	<b>1999 results</b>
Do not know	13%	22%
Protein food (meat, eggs, liver)	77.1%	72.5%
Green leafy vegetables	57.1%	36.5%

### **G.1.3. Knowledge regarding danger signs during pregnancy, delivery and postpartum period**

Regarding knowledge of danger signs during pregnancy, 48.2% mothers mentioned swelling of hands, face, feet and high blood pressure, 42.9% cited excessive vaginal bleeding, 34.2% mentioned anemia, 28.9% high fever and 13.6% premature rupture of membrane/passage of amniotic fluid. 21.6% mothers did not know. Sixty-seven percent mothers knew at least two or more danger signs during pregnancy.

<b>Danger signs during pregnancy</b>	<b>2003 results</b>	<b>1999 results</b>
Does not know	21.6%	17%
Excessive vaginal bleeding	42.9%	68%
Swelling of hands/face	48.2%	50%
Anemia	34.2%	29.4%
High fever	28.9%	19%
Early rupture of membrane	13.6%	14%
Others	3%	10%
Three signs or more	23.0%	27%
Two signs	44.2%	22%
One sign	21.6%	51%
Not relevant	11.2%	

Regarding danger signs during labor/delivery, 70% mentioned excessive vaginal bleeding, 62.3% mentioned retained placenta and 62.3% mentioned severe abdominal pain. 24.6% did not know. Sixty-nine percent mothers knew two or more danger signs during labor/delivery.

<b>Danger signs during labor/delivery</b>	<b>2003 results</b>	<b>1999 results</b>
Excessive bleeding	70%	64.5%
Retained placenta	62.3%	69%
Severe abdominal pain	62.3%	38%
Don't know	24.6%	12%
Others		
Three signs or more	2%	18%
Two signs	67.4%	40%
One sign	23.4%	42%
Irrelevant	7.1%	

Regarding danger signs during postpartum period, 66% mothers mentioned high fever, 37.9% mentioned problems with breastfeeding, 20.9% cited foul smelling vaginal discharge. 24.6% didn't know. Knowledge of mothers regarding two or more danger signs is 69.7% as compared to 29% in 1999.

<b>Danger signs during postpartum</b>	<b>2003 results</b>	<b>1999 results</b>
Do not know	24.6%	21%
High fever	66.1%	69%
Foul smelling vaginal discharge	20.9%	19%
Problems with breastfeeding	37.9%	23%
Others	9.3%	20%
Three signs or more	5.1%	4%
Two signs	64.6%	25%
One sign	30.1%	71%

## G.2. Childbirth

Of the total mothers, 93.4% (280/300) mothers delivered their child at home. Five percent (4.9%) delivered in the district hospital and 1.7% in private clinic. Sixty percent (59.8%) mothers were assisted by trained TBA/FCHWs and 20.9% by untrained TBA. Skilled attendants (doctors and female nurses) including two male doctors attended 13% of the deliveries. Untrained relatives assisted 5.6% mothers and a few (0.7%) delivered on their own.

<b>Birth attendants</b>	<b>2003 results</b>	<b>1999 results</b>
Untrained TBAs	20.9%	40%
Trained TBA/FCHWs	59.8%	31%
Skilled provider (doctors, nurses and midwives)	13%	9.1
Relatives (untrained)	5.6%	15.6%
Herself	0.7%	0.5%
Others	-	3.8%

Regarding what instrument was used to cut the umbilical cord, of those mothers who delivered at home, 91.8% mentioned a clean razor blade (56% in 1999), 7.1% a used razor blade, 0.4% a kitchen knife and 0.7% mentioned other unclean instrument.

### Postnatal care:

Of the total mothers, 84.1% (252/300) mentioned one type or more health workers examined them after delivery. Of these 97.2% mothers mentioned that their child was also examined. 57.3% mentioned that a trained TBA/FCHW provided postnatal care, 28.6% a doctor, 20% MCH assistants, 5.1% a nurse and 8.7% a midwife. 17% mentioned untrained TBAs.

<b>Postnatal care givers</b>	<b>2003 results</b>	<b>1999 results</b>
Untrained TBA	11.6%	2%
Trained TBA/FCHWs	44.3%	10%
Female doctors	28.1%	65%
MCH assistants	10%	23%
Nurses	3.2%	0%
Midwives	2.8%	0%

Regarding how many times the health workers provided postnatal check, 52.8% mentioned three or more times, 29.4% two times and 17.7% one time. 74.6% mothers mentioned that they were examined 24 hours after delivery, 10.3% after three days, 9.9% between seven to twelve days after delivery and 4% gave other comments.

<b>Postnatal care days</b>	<b>2003 results</b>	<b>1999 results</b>
After 24 hours	74.6%	66%
After three days	10.3%	8%
On the 7/12 day	9.9%	13%
Between 15-40 days	-	13%
Does not know	1.2%	-
Others	4%	-

## **H. Family Planning**

Of the total mothers (n=300) 7% were pregnant at the time of this survey and their youngest child was between 4-23 months old with mean at 18.8 months.

### **H.1. Methods:**

Of the total mothers who were not pregnant at the time of this survey, only 6.6% informed that they were practicing at least one modern family planning methods (9% in 1999). The most common methods used are oral contraceptives (57.1%) and injections (42.9%).

<b>Family planning methods</b>	<b>2003 results</b>	<b>1999 results</b>
Oral contraceptives	57.1%	23%
Injectables	42.9%	64%
Condoms (not reported)	0%	12.5%

Regarding sources from where they get their family planning supplies, most mentioned private practitioners (90%). 5% mentioned district hospital and 5% TBAs.

**ANNEX 2. REPORT OF BASELINE ASSESSMENTS**  
**B. KPC Survey: Jawzjan Province**

*Provincial Strengthening in Northern Afghanistan:  
Capacity Building and Innovation to Support Afghanistan's Basic Package of  
Health Services and Sustainably Improve Access, Quality and Use of Essential  
MCH Services throughout Jawzjan Province*

Cooperative Agreement No. GHS-A-00-03-00011-00.  
September 30, 2003 - September 30, 2008

**Afghanistan CS-19**  
**Baseline KPC Report**  
**Jawzjan, Afghanistan**

Prepared by

Save the Children/US

January 2004



## TABLE OF CONTENTS

### Acronym List

I.	Findings.....	4
A.	Project Indicators.....	4
B.	Demographics .....	4
C.	Maternal Newborn Care.....	6
D.	Breastfeeding and Infant/Child Nutrition.....	10
E.	Immunizations.....	12
F.	Care of the Sick Child.....	13
G.	Control of Diarrhea.....	14
H.	Acute Respiratory Infections.....	15
I.	Child Spacing.....	16
J.	HIV/AIDS.....	17
K.	Malaria.....	17
L.	Health Contacts and Sources of Information.....	17
II.	Summary Conclusions and Recommendations.....	18
III.	Attachments.....	24
A.	Questionnaire in Dari and English.....	25
B.	EPI INFO 6.04 Formulas for Calculating Program KPC Indicators.....	58
C.	List of Survey Participants.....	60

## ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ARI	Acute Respiratory Infection
BCG	Bacille Calmette-Guerin (Vaccination for tuberculosis)
BHC	Basic Health Center
CHC	Community Health Committee
CHW	Community Health Worker
CS	Child Survival
DPT	Diphtheria Pertusis Tetanus Vaccine
EPI	Expanded Program of Immunizations
FGD	Focus Group Discussion
FP	Family Planning
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
IHFA	Integrated Health Facility Assessment
IUD	Intrauterine Device
IV	Intravenous
KPC	Knowledge Practice and Coverage (Survey)
LAM	Lactational Amenorrhea Method
MCH	Maternal Child Health
MOH	Ministry of Health
NGO	Non Governmental Organization
NID	National Immunization Day
OPV	Oral Polio Vaccine
ORS	Oral Rehydration Solution
PPC	Postpartum Care
PNC	Prenatal Care
PRA	Participatory Rapid Appraisal
R	Recommendation
SC	Save the Children
SD	Standard Deviation
TBA	Traditional Birth Attendant
TT	Tetanus Toxoid Vaccine
VitA	Vitamin A

## I. FINDINGS

### A. PROJECT INDICATORS

The following table presents the baseline rates and the proposed targets for the project's eleven KPC-related indicators.

#	End of Project Targets/Indicators	Baseline	Target	Data Source/Notes
1	20% increase in mothers of children under 2 receiving 2 or more TT before birth of youngest child.	15% (44/300)	35%	By card: KPC Question 13.
		24% (72/300)	44%	By mothers' recall: KPC Question 15.
3	60% of 12-23 month olds fully immunized (against 6 diseases) by age 12 months.	4% (6/142)	60%	By card: KPC Questions 44 & 45.
5	80% of 12-23 month olds receive measles vaccine.	12% (17/142)	80%	By card: KPC Questions 44 & 45.
7	75% of 12-23 month olds received vitamin A in last 6 months.	69% (208/300)	75%	By recall: KPC Question 41.
9	25% increase in ill children receiving increased fluids & continued feeding during illness in past 2 weeks.	7% (14/205)	32%	KPC Questions 50-52.
10	25% increase in mothers reporting hand washing before food preparation & child feeding, & after defecation & child defecation.	17% (50/300)	42%	KPC Question 60.
12	15% increase in % of children <2 whose birth were attended by skilled health personnel.	28% (84/300) <sup>7</sup>	43%	KPC Question 26.
13	25% increase in mothers with 1/more postpartum check.	29% (87/300)	54%	KPC Question 30.
14	5% increase in non-pregnant mothers who desire no more children in next two years, or are unsure, who are using a modern method of child spacing.	17% (21/122)	22%	KPC Questions 67 & 68.
20	60% of mothers know 2 or more signs of child illness needing treatment.	14% (43/300)	60%	KPC Question 49.
21	20% increase in mothers with knowledge of at least 2 maternal danger signs during the postpartum period.	29% (87/300)	49%	KPC Question 35.

<sup>7</sup> Included in this cohort were doctors (20), nurses (2), midwives (40) and trained traditional birth attendants (22).  
CS-19 Afghanistan: *Provincial Strengthening*. DIP Draft. Save the Children, April 2004.

## B. DEMOGRAPHICS (KPC Questions 1-12)

**Language:** Six languages were represented in the communities surveyed, including the following:

Languages Spoken by the Mothers	Frequency (N = 300)	Percent
Uzbaki	142	47%
Turkmani	74	25%
Dari	40	13%
Pashto	25	8%
Arabi	18	6%
Tajek	1	1%
<b>Total</b>	<b>300</b>	<b>100%</b>

**Age:** The average age of the mothers interviewed was 31 and ranged from 16 to 46. Four percent (13/300) of the mothers were under the age of 20. Sixty-seven percent (201/300) had one biological child under the age of five living with them; 32% (95/300) had two; and only 1% (3/300) had three or more – resulting in an average of 1.3 biological children under the age of five living with each mother interviewed. The ages of the children whose mothers were interviewed is presented below:

Child's Age	Frequency (N=300)	Percent
Infants under six months	72	24%
Infants under 11 months	158	53%
Children between 12 and 23 months	142	47%
Infants/children between birth and 23 months	300	100%

**Education:** Only 13% (29/300) of mothers had ever attended school. Six percent (18/300) attended primary school and 6% (17/300) had attended secondary school.

**Employment:** The vast majority of mothers (94% or 282/300) do not work outside the home. The few who do are working in carpet weaving and handicrafts. The majority of their spouses (60% or 164/273) are working in agriculture, while others are salaried workers (15% or 40/273) or shopkeepers (14% or 37/273). Nine percent (27/300) of spouses are reportedly unemployed.

**Child Care:** Most mothers (32% or 96/300) reported that they take their children with them when they leave the house. Of the others, 36% (107/300) reported they leave the child with a grandmother and 25% (74/300) report that they leave the child with older siblings. Only 2% (6/300) said that their husbands take care of the child. There is no appreciable difference in these rates when taking the gender of the youngest child into account.

## C. MATERNAL NEWBORN CARE (KPC Questions 13-37)

### Antenatal Care (KPC Questions 13-24)

**Attendance at ANC:** Roughly two thirds of mothers (66% or 199/300) reported having seen someone for antenatal care (ANC) during their most recent pregnancy and 44% (131/300) received ANC two or more times. This care was provided by the following:

Sources of ANC	Frequency (N=199)	Percent
Private Doctor	73	37%
MOH Nurse/Midwife	64	32%
MOH Physician	49	24%
Traditional Healer/Mullah	7	4%
Traditional Birth Attendant	6	3%
<b>Total</b>	<b>199</b>	<b>100%</b>

**Reasons for not seeking ANC:** Of the mothers who did not seek ANC, 39% (39/101) were not aware of the need for care; 39% (39/101) said that distance was a factor; 12% (12/101) said they were not permitted by their family to seek care; and only 3% (3/101) said they did not have enough money.

**ANC Cards:** Of the 199 women who sought ANC, 88% (175/199) reported never having received an ANC card and only eight mothers had a card that they could show the interviewers.

**Tetanus Toxoid (TT) Immunization:** A majority of mothers (72% or 217/300) never received or were unable to produce a TT immunization card. Based on a review of the cards, only 15% (44/300) of mothers had received two or more doses of TT. Each of the mothers was also asked whether she remembered having had a TT vaccination and 24% (72/300) reported having received two or more based on recall.

**Diet and anemia:** A significant majority of mothers (63% or 189/300) reported eating less than usual during their most recent pregnancy, while 31% (93/300) reported eating the same amount and only 6% (18/300) reported eating more than usual. Mothers' knowledge of foods that can prevent anemia was mixed. While 63% (189/300) of mothers recognized that protein-rich foods would prevent anemia, only 27% (81/300) noted green leafy vegetables. Of the mothers who sought prenatal care, 32% (63/199) reported receiving iron tablets. The remaining 67% (134/199) of mothers who received ANC reported that they did not receive or could not remember receiving iron tablets. Therefore, overall coverage for iron supplementation for pregnant women is estimated at 21% (63/300).

**Knowledge of and responding to pregnancy-related danger signs:** Mothers listed the following danger signs as symptoms that would lead them to seek healthcare services during pregnancy:

<b>Prenatal Danger Signs</b>	<b>Frequency (N = 300)</b>	<b>Percent</b>
Bleeding	154	51%
Fever	79	26%
Swelling	56	19%
Breathlessness	51	17%

In sum, 42% (125/300) of mothers were able to identify two or more danger signs and 18% (54/300) were not able to identify any. The 255 mothers who stated one or more danger signs said they would seek medical care to treat these ailments from the following:

<b>ANC Providers</b>	<b>Frequency (N=255)</b>	<b>Percent</b>
Hospital	133	52%
Private Practitioner	74	29%
Traditional Practitioner	14	6%
NGO Clinic	10	4%
MCH Clinic	9	3%
Mulla	8	3%
BHC	5	2%
Mobile Clinic	2	1%
<b>Total</b>	<b>255</b>	<b>100%</b>

### **Delivery and Immediate Newborn Care (KPC Questions 25-29)**

**Delivery:** A total of 89% (266/300) of children were delivered at home – outside health facilities. Only 6% (18/300) of mothers delivered at a private doctor’s clinic and 5% (14/300) delivered at a hospital. Only 28% (84/300) of deliveries were attended by a skilled health professional, such as a doctor, nurse, midwife, or a trained TBA, as noted below.

<b>Assistance at Deliveries</b>	<b>Frequency (N=300)</b>	<b>Percent</b>
<b>Skilled Health Professional</b>		
Midwife	40	13%
Trained TBA	22	7%
Doctor	20	7%
Nurse	2	1%
<b>Subtotal</b>	<b>84</b>	<b>28%</b>
<b>Unskilled Attendant</b>		
Untrained TBA	114	38%
Untrained Relative	71	24%
Herself	10	3%
Trained Relative	10	3%
Husband	10	3%
Don’t know	1	1%
<b>Subtotal</b>	<b>216</b>	<b>72%</b>
<b>Total</b>	<b>300</b>	<b>100%</b>

Ninety-three percent (280/300) of mothers reported that a razor was used to cut the cord. Also reported were bamboo, knife and scissors.

**Immediate Newborn Care:** Upon birth, 75% (224/300) of newborns were put with their mothers; 16% (47/300) were put on the floor; and 7% (21/300) were put on a cot. The majority of newborns (85% or 254/300) were bathed within the first hour after birth and 11% (32/300) were not bathed until after the first day.

### Postpartum Care (KPC Questions 30-37)

**Attendance at PPC:** Only 29% (87/300) of mothers reported that their health was checked after their most recent delivery. They were seen by:

Sources of PPC	Frequency (N=87)	Percent
Midwife	42	48%
Doctor	33	38%
Traditional healer	5	6%
TBA	3	4%
Nurse	2	2%
Mother	1	1%
Did not know	1	1%
<b>Total</b>	<b>87</b>	<b>100%</b>

The average length of time between the delivery and the first PPC visit was 4.2 days, with the majority of mothers (47% or 41/87) being seen the day following delivery. Of the mothers who attended PPC, a majority (66% or 57/87) reported only one visit.

**Health education during PPC visits:** The mothers who received PPC were counseled on the following topics:

PPC Counseling Topics	Frequency (N=300)	Percent
Childhood immunizations	36	12%
Breastfeeding	21	7%
Infant nutrition	15	5%
Family planning	9	3%
Early signs of pneumonia	9	3%
Infant diarrhea	8	3%

**Postpartum danger signs for the mothers:** Mothers listed the following PP danger signs for which they would seek healthcare:

Postpartum Danger Signs	Frequency (N=300)	Percent
Excessive bleeding	212	71%
Abdominal pain	57	19%
Back pain	45	15%
Smelly vaginal discharge	21	7%

In sum, the number of mothers who knew the postpartum danger signs:

Knowledge of PP Danger Signs: # of Correct Answers	Frequency (N=300)	Percent
0	54	18%
1	159	53%
2	77	26%
3	10	3%
<b>Total</b>	<b>300</b>	<b>100%</b>

**Postpartum danger signs for the newborn:** During PPC visits 70% (61/87) of mothers reported that the health of their newborn child was checked as well. Mothers listed the following danger signs in newborn children for which they would seek healthcare:

Newborn Danger Signs	Frequency (N=300)	Percent
Fast breathing	164	55%
Poor feeding	97	32%
Redness around the cord	81	27%
Inactive	74	25%
Discharge around the eyes	74	25%

In sum, the number of mothers who knew the danger signs in newborn children:

Knowledge of Newborn Danger Signs: # of Correct Answers	Frequency (N=300)	Percent
0	33	11%
1	80	27%
2	153	51%
3	25	8%
4	9	3%
<b>Total</b>	<b>300</b>	<b>100%</b>



## D. BREASTFEEDING AND INFANT/CHILD NUTRITION (KPC Questions 25-29)

**Breastfeeding:** The vast majority of mothers (98% or 294/300) report having breastfed their youngest child at some point. Breastfeeding was initiated:

Initiation of Breastfeeding	Frequency (N=294)	Percent
Within the first hour	180	61%
Between hours two and eight	19	6%
Between hours nine and 24	8	3%
After the first day	86	29%
Cannot remember	1	1%
<b>Total</b>	<b>294</b>	<b>100%</b>

Roughly two thirds of infants under six months of age (68% or 49/72) were being exclusively breastfed. Ninety percent (204/228) of mothers of children between 6 and 23 months of age were continuing to breastfeed. Sixty-seven of these mothers were pregnant at the time of the survey and 75% (50/67) of them were continuing to breastfeed during their pregnancy. By contrast, 96% (154/161) of mothers who were not pregnant were still breastfeeding, which represents a difference of 21 percentage points.<sup>8</sup>

**Vitamin A:** Sixty-nine percent (208/300) of mothers reported that their youngest child had received a dose of vitamin A (VitA) within the past six months. This rate of VitA coverage is relatively high, especially when considered within the context of the very low EPI rates noted below. Vitamin A is given as part of the NIDS/polio campaigns and is not recorded on the cards, so the project showed mothers a VitA capsule to see if their child had received one at a national immunization day (NID).

**Growth monitoring:** Ninety percent (270/300) of mothers consented to having their youngest child weighed – 126 girls and 144 boys. Thirty percent (38/126) of the girls and 34% (49/144) of the boys fell under the second standard deviation (SD) measured weight-for-age and over half (56% or 152/270) fell under the first SD.

Girls Weight-for-Age										
Age Months	Total Measured	Lower SD	-3 SD	-2 SD	-1 SD	Mean	+1 SD	+2 SD	+3 SD	Upper SD
0	2	0.5			1	1				0.4
1	6	0.6	1		2	3				0.5
2	7	0.7		1	1	5				0.7
3	5	0.7				4	1			0.8
4	3	0.8				1	1	1		0.8
5	6	0.8				5	1			0.9
6	13	0.9		1	5	5	2			0.9
7	3	0.9				3				0.9
8	8	0.9	2		5	1				1.0

<sup>8</sup> Breastfeeding is promoted through the Qur'aan, which states that a girl must be breastfed for two and a half years and a boy for two years. However, commonly held beliefs that a mother's milk goes bad during pregnancy could explain the difference in the breastfeeding rates between non-pregnant and pregnant mothers. Breastfeeding Research, Andkhoy, Afghanistan, SC/US, 2002.

Girls Weight-for-Age										
Age Months	Total Measured	Lower SD	-3 SD	-2 SD	-1 SD	Mean	+1 SD	+2 SD	+3 SD	Upper SD
9	2	1.0				2				1.0
10	6	1.0				4	2			1.0
11	3	1.0		1	1	1				1.0
12	11	1.0		6	1	4				1.0
13	10	1.1	1	5	1	3				1.1
14	2	1.1				1	1			1.1
15	3	1.1		3						1.1
16	3	1.1		2	1					1.1
17	5	1.2	1	2	1	1				1.1
18	6	1.2	1	2	3	1				1.1
19	2	1.2		1	1					1.2
20	3	1.2	1		2					1.2
21	4	1.2		1		3				1.2
22	6	1.2		2	3	1				1.2
23	6	1.2		4	2					1.3
<b>TOTAL</b>	<b>126</b>	<b>N/A</b>	<b>7</b>	<b>31</b>	<b>30</b>	<b>49</b>	<b>8</b>	<b>1</b>	<b>0</b>	<b>N/A</b>
	<b>100%</b>		<b>5%</b>	<b>25%</b>	<b>24%</b>	<b>39%</b>	<b>6%</b>	<b>1%</b>	<b>0%</b>	

Boys Weight-for-Age										
Age Months	Total Measured	Lower SD	-3 SD	-2 SD	-1 SD	Mean	+1 SD	+2 SD	+3 SD	Upper SD
0	4	0.4			2	1	1			0.5
1	4	0.7			3	1				0.7
2	5	0.9		1	1	2	1			0.8
3	14	1.0		1	2	8	3			0.9
4	2	1.0		1		1				0.9
5	6	1.0			3	2	1			0.9
6	12	1.0	2	1	3	4	1		1	1.0
7	3	1.0			1	2				1.0
8	11	1.0		2	3	5		1		1.0
9	7	1.0	1	1	1	3	1			1.0
10	1	1.0		1						1.1
11	9	1.0	1	3	1	3	1			1.1
12	13	1.0	2	6	1	2	1		1	1.1
13	8	1.0		4	3	1				1.1
14	7	1.1	1	1	1	4				1.2
15	7	1.1	1	2	1	2			1	1.2
16	5	1.1		4	1					1.2
17	5	1.1	1		4					1.2
18	4	1.2	1	2	1					1.2
19	8	1.2	2	2	3	1				1.2
20	2	1.2	1	1						1.3
21	1	1.3				1				1.3
22	4	1.3	2			2				1.3
23	2	1.3		1				1		1.3
<b>TOTAL</b>	<b>144</b>	<b>N/A</b>	<b>15</b>	<b>34</b>	<b>35</b>	<b>45</b>	<b>10</b>	<b>2</b>	<b>3</b>	<b>N/A</b>
	<b>100%</b>		<b>10%</b>	<b>24%</b>	<b>24%</b>	<b>32%</b>	<b>7%</b>	<b>1%</b>	<b>2%</b>	

## E. IMMUNIZATION (KPC Questions 44-48)

Only one fourth of mothers (23% or 69/300) had an EPI card available to review. Of the children between the ages of 12 and 23 months, 4% (6/142) were fully immunized per card and 12% (17/142) had had their measles vaccination per card. Also per card, 22% (31/142) had had BCG; 12% (17/142) had had OPV3; and 11% (16/142) had had DPT3. The DPT dropout rate is 47%. Of the 32 children between the ages of 12 and 23 months who had EPI cards, 31 mothers reported that their child had had more immunizations than were recorded on the card. All 31 mothers reported by card that their child had received BCG and OPV; 30 reported that their child had received DPT; and 21 reported that their child had received the measles vaccine.

Seventy-seven percent (110/142) of mothers of children between the ages of 12 and 23 months did not have an EPI card available at the time of the interview, the majority (69% or 76/110) reporting never having received one. Of the mothers who did not have an EPI card available, 84% (92/110) reported that their child had received one or more vaccinations. Of these, 48% (44/92) reported that their child had received BCG; 96% (88/92) reported receiving OPV, with 41% (36/88) reporting that they had received it at birth and 38% (33/88) reporting that they had received four or more doses; 34% (31/92) reported having received DPT and 12% (11/92) reporting that they received three or more doses; and 30% (28/92) reported receiving the measles vaccination.

## F. CARE OF THE SICK CHILD (KPC Questions 49-64)

**Danger signs:** Each mother was asked to list the signs of illness that would indicate that a child needed care or treatment:

Signs of Childhood Illness Requiring Care	Frequency (N=300)	Percent
Fever	222	74%
Fast or difficult breathing	174	58%
Vomits everything	96	32%
Bloody diarrhea	82	27%
Diarrhea lasting over two weeks	67	22%
Not eating	58	19%
Convulsions	34	11%
Lethargy	12	4%
Does not know	9	3%

**Most common ailments:** When asked if their youngest child had experienced any of the following in the past two weeks, mothers reported:

Signs of Childhood Illness Experienced in the Previous Two Weeks	Frequency (N=300)	Percent
Diarrhea	126	42%
Blood in the stool	26	9%
Cough	96	32%
Fast Breathing/Short, quick breaths	73	24%
Fever	116	39%
Malaria	6	2%
Convulsions	17	6%
Vomiting	11	4%
None of the above	95	32%

**Feeding the sick child:** Of the mothers who reported that their child had been sick within the past two weeks, only 23% (45/199)<sup>9</sup> reported that they had offered more to drink and only 26% (51/198)<sup>10</sup> reported that they had offered the same amount or more to eat.

## G. CONTROL OF DIARRHEA (KPC Questions 53-60)

**Prevention:** All mothers were asked to list the times when they usually wash their hands:

Hand Washing Practices	Frequency (N=300)	Percent
After defecating	212	71%
Before food preparation	181	60%
After attending a child who has defecated	170	57%
Before eating	141	47%
Before feeding children	95	32%
Never	14	5%

In sum, 17% (50/300) said that they usually wash their hands before preparing food, before feeding the children, after defecating, and after attending to a child who has defecated.

<sup>9</sup> This question was asked of 205 mothers whose children had been sick, however, only 199 responded.

<sup>10</sup> This question was asked of 205 mothers whose children had been sick, however, only 198 responded.  
CS-19 Afghanistan: *Provincial Strengthening*. DIP Draft. Save the Children, April 2004.

**Home-based case management:** Forty-four percent (132/300) of mothers reported their child had experienced diarrhea and/or blood in the stool in the two weeks prior to the survey. The mothers had treated their children with the following:

<b>Treatment for Diarrhea Provided by Mothers</b>	<b>Frequency (N=132)</b>	<b>Percent</b>
Pill or syrup	89	67%
Injection	36	27%
ORS	30	23%
Homemade fluids	26	20%
Home remedies/herbal medicines	13	10%
Nothing	11	8%
Antibiotics provided by shopkeepers	9	7%
IV Intravenous	7	5%

All 300 mothers interviewed were asked to demonstrate how to prepare ORS. Of the 297 who agreed, fewer than half, (46% or 138/297) prepared it correctly.

**Knowledge of danger signs:** All mothers were asked what diarrhea-related symptoms would cause them to seek advice or treatment for their sick child:

<b>Diarrhea-Related Danger Signs</b>	<b>Frequency (N=300)</b>	<b>Percent</b>
Fever with diarrhea	188	63%
Severe vomiting	129	43%
Diarrhea lasting <14 days	120	40%
Bloody diarrhea	18	6%

In sum, the following knew the correct number of symptoms:

<b>Knowledge of Diarrhea-Related Danger Signs: # of Correct Answers</b>	<b>Frequency (N=300)</b>	<b>Percent</b>
0	19	6%
1	96	32%
2	155	52%
3	27	9%
4	3	1%
<b>Total</b>	<b>300</b>	<b>100%</b>

**Care seeking:** Medical treatment was sought for children with diarrhea from the following providers:

Sources of Care for Diarrheal Disease	Frequency (N=132)	Percent
Private practitioners	54	41%
Government Health Facility Staff	28	21%
Self only	20	15%
Traditional Healers	11	8%
Village Pharmacy	7	6%
Friend or Neighbor	7	6%
Don't know	5	3%
<b>Total</b>	<b>132</b>	<b>100%</b>

Of concern, mothers reported that 86% (24/28) of government health facility staff and 57% (31/54) of private practitioners provided antidiarrheals to treat diarrhea in children. One fifth (20% or 11/54) of private practitioners counseled mothers to restrict the diet they are feeding their children. Only 37% (20/54) of private practitioners and 79% (22/28) of government health staff suggested giving ORS.

## H. ACUTE RESPIRATORY INFECTIONS (KPC Questions 61-64)

**Care seeking:** Thirty-nine percent (116/300) of mothers reported seeking advice or treatment when their child experienced cough and fast breathing during the two weeks prior to the survey. One hundred fifteen mothers responded to the question, how long did they wait from the time they first noticed these symptoms until they sought treatment:

Number of Days Between Recognition of Symptoms and Care Seeking	Frequency (N=115)	Percent
Same day	18	15%
Next day	39	34%
Two days	24	21%
Three or more days	34	30%
<b>Total</b>	<b>115</b>	<b>100%</b>

The children were brought to the following for care:

<b>Sources of Care for ARI</b>	<b>Frequency (N=116)<sup>11</sup></b>	<b>Percent</b>
Private Doctor	39	34%
Hospital	34	29%
Traditional Practitioner	23	20%
MCH Clinic	6	5%
BHC	4	3%
NGO Clinic	3	3%
Pharmacy	2	2%
Mullah	1	1%
Self	1	1%

## **I. CHILD SPACING (KPC Questions 65-68)**

When asked to identify a place where family planning supplies could be obtained, 61% (184/300) of mothers said they did not know. The others listed the following:

<b>Sources for Family Planning Supplies</b>	<b>Frequency (N=300)</b>	<b>Percent</b>
Hospital	64	21%
Other health facility	24	8%
Private doctor	13	4%
MCH Clinic	10	3%
BHC	7	2%
Traditional Healers	7	2%

Of the 300 mothers interviewed, a total of 122 were not currently pregnant and either did not want to become pregnant or were not sure. Of these, 17% (21/122) were using a modern method of family planning as noted below:

<sup>11</sup> Multiple responses were allowed to this question.

<b>Use of Family Planning Methods by Mothers Who Are Not Pregnant and Do Not Want Another Child or are Unsure</b>	<b>Frequency (N=122)</b>	<b>Percent</b>
None	48	39%
<b>Modern Methods</b>		
Injectons	10	8%
Pill	7	6%
Norplant	2	2%
Condom	1	1%
IUD	1	1%
<b>Other Methods</b>		
LAM	46	37%
Rhythm	4	3%
Other	3	3%
<b>Total of All Methods</b>	<b>122</b>	<b>100%</b>

#### **J. HIV/AIDS (KPC Questions 69-70)**

Only 3% (9/300) of mothers have heard of AIDS. When asked how it could be prevented, four stated by avoiding sex with prostitutes, one said by avoiding injections, and the other four said they did not know.

#### **K. MALARIA (KPC Questions 71-73)**

Fifty-one percent (152/300) of mothers reported that they have at least one bednet in their home. In 44% (131/300) of households the children slept under the net the previous night and in roughly the same number (86% or 130/300), the mother did as well. Only 15% (23/152) of the nets were sprayed within the past year.

#### **L. HEALTH CONTACTS AND SOURCES OF INFORMATION (KPC Questions 74-75)**

Mothers reported receiving advice on health and nutrition from the following individuals:

<b>Sources of Advice on Health and Nutrition</b>	<b>Frequency (N=300)</b>	<b>Percent</b>
Doctors	39	13%
CHWs and TBAs	19	6%
Nurses	11	4%
Trainers/Health Educators	4	1%
CHC Members	3	1%
Others	1	1%



Mothers identified the following sources for health education messages they had heard over the month prior to the survey:

Sources of Health Education Messages	Frequency (N=300)	Percent
Television	22	7%
Radio	21	7%
Health Educator (CHW)	11	4%
CHC Member	10	3%
Newspaper	8	3%
EPI Campaign	8	3%

## II. SUMMARY CONCLUSIONS and RECOMMENDATIONS:

The project proposed to implement the following six child survival interventions in its application at the estimated level of effort for each:

- Immunization (25%)
- Maternal and Newborn Care (20%)
- Pneumonia Case Management (20%)
- Control of Diarrheal Diseases (15%)
- Child Spacing (15%)
- Nutrition and Micronutrients, focused on vitamin A supplementation through EPI (5%)

This section of the report summarizes the primary challenges that have surfaced from the KPC results and recommends next steps. It is important to recognize that KPC surveys provide a picture of what mothers know, do, and seek out in terms of services for the health of their child. KPC surveys are not, however, as effective at answering the important ‘why’ or ‘how’ questions like –‘Why are women deciding to deliver their babies at home?’ ‘How can the project convince mothers to initiate breastfeeding the first day?’ These questions are best answered by talking directly with health workers, mothers, community leaders, and other stakeholders through focus group discussions (FGD), structured interviews, and the menu of strategies that fall under the heading of participatory rapid appraisal (PRA). These discussions have already begun with the MOH and their findings are included here as well.

**Immunization:** Immunization coverage for children is very low; the DPT dropout rate is high; and less than one fourth of caregivers had EPI cards for their children. In meetings with the MOH to discuss the KPC results, the following reasons for the low immunization coverage were mentioned:

- More emphasis has been placed on the polio eradication campaigns, which have reduced efforts to improve routine immunization at health facilities.
- There is a lack of female vaccinators in the clinics because the female literacy rates in the rural areas are very low, making it difficult to recruit and train qualified candidates into these positions. The low salary rate for vaccinators is also a factor.
- Opportunities are being lost because health workers are not screening women for their immunization status or asking them for their EPI cards when they come to health facilities.

- Vaccinators are receiving little or no useful feedback due to the poor quality of monitoring and supervision.
- Very little is being done in outreach activities and health education. Few of the health facilities have female health educators.
- There is a lack of awareness in the general population about the importance and timing of immunization.

Recommendation (R) 1: Based on what has been learned to date, the three immunization-related objectives (1, 3 and 5) appear to be appropriate. However, the baseline rates for fully immunized 12-23 month olds (objective 3) and for 12-23 month olds who received measles vaccine (objective 5) are extremely low when compared to their targets (4 % increased to 60% and 12% increased to 80%, respectively). Therefore, the targets of these objectives might be too optimistic and could be scaled back.

R2. The reasons why so few mothers have EPI cards for their children should be explored through interviews with MOH staff about supply and with mothers about retention.

R3. FGDs should be held with mothers to identify any cultural, economic, or systemic factors that might be leading to the low EPI coverage and discuss ways that the project can increase this coverage.

**Maternal and Newborn Care:** Very few mothers had an ANC or TT immunization card, and while roughly two thirds of them had seen a health worker during their pregnancy, fewer than a fourth could remember or document by card having received a TT vaccination. Nearly two thirds of women ate less during their pregnancies even though most were aware of at least some foods that prevent anemia and only about one fifth of pregnant women received iron supplements. The vast majority of children are being delivered in homes assisted by unskilled individuals. Just under one third of mothers had their health checked following the delivery. Even for the mothers attending PPC, very few were receiving health education for themselves or their newborns.

The MOH identified the following reasons for the high number of births that were not attended by trained health workers, the low level of maternal knowledge on postpartum danger signs, and the reasons why so few mothers were going to at least one postpartum checkup:

- Most of the clinics lack basic MCH services and there is no client counseling or education provided so women are not developing birth-planning strategies for their deliveries.
- There is a lack of trained TBAs throughout much of the project area.
- The salary rates for female health workers are low so there is little or no incentive for women to come from outside the district to the project area to work in MOH facilities.
- Many women are going to untrained drug vendors where they can purchase uterotonics, antibiotics, and analgesics. With these drugs they no longer feel it is necessary to go to the clinic for the delivery or for a postpartum checkup.
- The distance to the nearest health facility is prohibitive for many women.

R4. The three objectives (12, 13, and 21) for the maternal newborn care intervention appear to be appropriate based on what was learned in the KPC and in the follow-up discussions with the

MOH. However, nutritional status during pregnancy is not addressed in these objectives and could be a significant problem, contributing to anemia and underweight babies. Reasons why pregnant women are eating less during their pregnancies should be explored in FGDs with mothers and programmatic responses considered.

R5. FGDs should be held with mothers/women to gain their perspective on reasons why women are not seeking ANC and PNC services, why so few women have TT/ANC cards, and why most women are delivering their children at home instead of at a health facility.

R6. The quality of assistance provided by both trained and untrained birth attendants to women delivering at home should be assessed. This could be done through interviews with new mothers and/or TBAs when they come to health facilities to receive their clean delivery kit.

R7. Ways to integrate ANC/PPC within the existing MCH activities need to be considered. For instance, TBAs appear to play a significant role in delivering the vast majority of children. However, they are not involved in ANC, developing delivery plans, or PPC. Ways to expand their role into these areas could be explored with the TBAs and health facility staff.

R8. Overall issues related to the very initial handling of the newborn baby should be explored further, particularly relating to bathing, skin-to-skin contact with the mother, and early initiation of breastfeeding. Specifically, are there cultural or religious beliefs surrounding delivery that need to be taken into account in developing appropriate health education messages and strategies? This could be researched through FGDs with women.

***Care of the Sick Child, Including Control of Diarrhea and Pneumonia Case Management:***

Only about one fourth of mothers knew the diarrhea danger signs that would necessitate care or treatment, while knowledge of fast/difficult breathing and fever was better at 58% and 74%, respectively. Of concern, only about a quarter of mothers said that they gave their child more fluids when the child was sick and the same number said they provided the same amount or more feedings.

Specific to the control of diarrhea, fewer than one fifth of mothers knew the four times that they should wash their hands and fewer than half were able to demonstrate the correct procedure for preparing oral rehydration solution. The most common forms of home-based case management for diarrhea were pills/syrup and injections, with only a fourth of mothers saying they provided ORS. The care and counseling received at health facilities is troubling, with many health workers providing antidiarrheals, some counseling mothers to restrict their child's diet, and only about a third of MOH workers promoting use of ORS. The delay in seeking care and treatment was the primary concern regarding ARI, with 85% of mothers waiting a day or longer.

In talking with the MOH staff about child health-related preventive, home care measures, and danger signs, the following factors were raised:

- Most health workers have not received training on patient counseling, so few are equipped to actively engage the caregivers in a dialog when they bring their sick children to the health facilities.
- No health education or community awareness campaigns have taken place in the rural areas.

- There is a lack of outreach health education, CHWs, health education materials in the local languages, and mass media in most districts.
- There is a lack of female health educators in most clinics.
- There is a low literacy rate and lack of awareness about health in the communities.

R9. The three related KPC objectives (9, 10, and 20) cover most of the primary issues of concern noted above and the IHFA objective #26 covers the lack of support for ORS and the inappropriate use of antidiarrheals. The only problem identified above, which is not directly addressed by an objective, is the need for timely treatment of ARI. This could be included as a 'practice' indicator (i.e. the number of children with fast/difficult breathing who are brought to a health facility the same day that these symptoms are recognized) and incorporated into the project's community health education efforts.

R10. FGDs should be held with mothers to garner their perspectives on why:

- Many mothers are decreasing the amount of fluids and food they provide to sick children.
- Many mothers are not considering bloody or persistent diarrhea as danger signs that require treatment.
- Few mothers are providing ORS to treat childhood diarrhea.
- Some mothers are waiting three or more days to seek care for ARI-related symptoms in their children, especially when these are some of the most commonly recognized danger signs. Are they using home remedies to treat ARI before they seek care outside? What are these home care remedies and when do they use them?
- Few mothers are taking their sick children to BHCs.

**Child Spacing:** The most popular form of family planning is LAM, and only one sixth of the mothers who were not pregnant and did not want another child were using a modern FP method. Nearly two thirds of the mothers surveyed said they did not know where they could get family planning supplies. MOH representatives noted the lack of family planning programs in most clinics, the lack of awareness about methods, and the fact that women are not the decision makers in the family as the main reasons for the very limited use of modern FP methods. The single KPC objective (# 14) will measure the project's impact on these challenges.

R11. FGDs held separately with men and women would be useful in exploring how family planning decisions are being made by couples and the reasons why. This can help to inform the project's IEC strategies.

R12. It is not clear from the KPC results whether the low rates of use of modern FP methods are the result of insufficient supply, lack of knowledge on their availability/efficacy, or a lack of interest due to cultural, religious, or other factors. A better understanding of these issues is critical to the design of the project's health education components.

R13. Since it is the most popular form of family planning used in the project area, further research should be done to find out whether women who are using LAM have a sufficient understanding of what is required for it to work (i.e. technically sound counseling, early initiation of breastfeeding, frequency of feedings day and night, understanding of when it is no longer an effective family planning method, the potential need for/timing of secondary forms of FP, etc.).

***Vitamin A supplementation through EPI (5%):*** Two thirds of mothers reported that their child had received a VitA capsule within the previous six months, which is just six percentage points below the target for objective 7.

R14. The target for VitA coverage (objective 7) should either be increased or the entire objective removed because this rate is already relatively high when compared to other challenges related to nutrition and breastfeeding. As an alternative, the project could focus on one or more of the following:

- While the overall rates for breastfeeding were very positive, about one third of mothers were waiting over 24 hours to initiate breastfeeding.
- Some mothers have stopped breastfeeding due to the mistaken belief that their breast milk goes bad when they are pregnant.
- About one third of children measured weight-for-age fell under the second standard deviation – an indicator of childhood malnutrition.

FGDs with mothers would help to inform ways to respond to these issues. Questions could include:

- Why are some mothers delaying the initiation of breastfeeding?
- Why are some mothers weaning their children before they are six months of age?
- What are mothers using to wean their children?

**Other issues:** *The following issues were not included in the project interventions, but surfaced in the KPC.*

R15. Knowledge of HIV/AIDS is extremely low in mothers and while it might not be considered a problem at present, several factors that currently exist could lead to its spread in the project area, including displaced populations, civil conflict/instability, lack of health education/counseling, and extremely limited use of condoms. Gender-based differences in knowledge about HIV/AIDS should be explored using FGDs, which could highlight issues that would benefit from a programmatic response.

R16. Over half of the mothers interviewed reported they have a bednet in their home, which could mean higher rates of malaria than was originally thought. In addition, fever was the second most common ailment reported in children over the two weeks prior to the survey and was the most common ailment that would lead mothers to take their child to a health worker for treatment. PRA strategies could be used with mothers to help them list and prioritize the most serious MCH problems to see if malaria is a major concern within the community. Also, the malaria-related results from the Integrated Health Facility Assessment should be closely reviewed in this context to further assess the extent that malaria might be a problem and to identify gaps that the project might be able to address. Interviews with the MOH should be done to find out who is providing the bednets and whether they are being re-sprayed.

R17. In developing its community-targeted IEC strategies, the project should consider:

- The low literacy rate of mothers, implied in the number of mothers who attended school that necessitates the use of visual, pictorial and oral rather than written IEC methods.

- IEC strategies will need to reach into the homes where mothers spend most of their time and also target the spouses and other decision makers and caregivers within the family.
- How and when do people come together (for religious ceremonies, at work, at communal water sources, etc.) and are these potential venues for providing IEC?
- Are there any pre-existing social, religious, or other types of groups that could support community mobilization and IEC?
- While the KPC results suggested that fathers have a very limited role in taking care of the children, one study<sup>12</sup> showed that they maintain a significant level of decision-making authority with regard to health in the family. This could be true for this population surveyed. Ways that this can be influenced should be explored. Related questions could include: Who decides when to go to a healthcare worker? Who decides where the delivery will take place and who will attend?

---

<sup>12</sup> Child Mortality Survey, Afghan Refugee Camp, Haripur, Pakistan. SC/US December 2003  
CS-19 Afghanistan: *Provincial Strengthening*. DIP Draft. Save the Children, April 2004.

## ATTACHMENTS

# ATTACHMENT A

## سروي (دانش، عمل وپوښش)

3 نومبر 2003

رهنمود اساس- سروي- سي اس 19

اسلام وعلیکم، اسم من \_\_\_\_\_ است. من برای موسسه همایه اطفال ریاست صحت کار میکنم. ما سروي صحي را براه میندازیم. از اشتراك شما دراین سروي استقبال میکنم. من درمورد صحت شما وکوچکترین طفل تان که از دوسال خردتر باشد سوال خواهم کرد. معلومات تان جهت پلان نمودن عرضه خدمات صحي و ارزیابی اینکه، این خدمات اهداف تعیین شده برای بهبود صحت اطفال را برآورده میسازد به موسسه همایه اطفال ریاست صحت کمک خواهد کرد. این سروي 45 دقیقه وقت را خواهد گرفت. معلومات ارایه نموده تان به کسی نشان داده خواهد شد.

اگرچه معلومات تان دراین سروي ارزنده میباشد. اما شما میتوانید به سوال های که دل تان خواست جواب ندهید.

حالا میخواهید درمورد سروي ازمن چیزی بپرسید؟

امضای سروي کننده \_\_\_\_\_

تاریخ \_\_\_\_\_

موافق است تا به مصاحبه ادامه دهد.

موافق نیست تا به مصاحبه ادامه دهد. / ختم

نمبر ثبت \_\_\_\_\_ (300-001)

تمام سوالات متوجه مادران که طفل سن پایینتر از دوسال دارند متوجه میباشد:

1. تاریخ مصاحبه : \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ روز/ماه/سال
2. اسم مصاحبه کننده :
3. اسم نوت گیرنده :: \_\_\_\_\_
- ولسوالی/ ناحیه : \_\_\_\_\_ قریه / گذر:

4. اسم مادر (در صورت امکان) \_\_\_\_\_
5. سن مادر به سال \_\_\_\_\_
6. چند طفل پائینتر از پنج ساله درین حویلی زندگی میکند؟ \_\_\_\_\_ اگر هیچ، مصاحبه را در همینجا خاتمه دهید.
7. چند طفل پائینتر از پنج ساله از خود تان است؟ \_\_\_\_\_ اگر هیچ، مصاحبه را در همینجا خاتمه دهید.
8. یکی از سوالات ذیل را به ارتباط جواب سوال 7 بخوانید :  
فقط يك طفل پائینتر از پنج ساله :  
اسم \_\_\_\_\_ تاریخ تولد : روز \_\_\_\_\_ ماه \_\_\_\_\_ سال \_\_\_\_\_  
بیشتر از يك طفل پائینتر از پنج ساله:

تاریخ تولد	جنس	اسم طفل	
روز _____ ماه _____ سال _____			1
روز _____ ماه _____ سال _____			2
روز _____ ماه _____ سال _____			3

شماره	سوال ها و تفکیک ها	کود ها
9	آیا شما گاهی مکتب خوانده اید؟ اگر جواب خیر باشد: نمبر 1 را حلقه نماید اگر بلی باشد : بلندترین سطح تحصیل تان در مکتب چند است؟	<p>خیر</p> <p>.....</p> <p>1 ..... ابتدایه</p> <p>.....</p> <p>2 ..... .....</p>



	متوسطه ..... ... 3 عالي ..... 4 .....		
10	آيا شما درخارج از منزل كار ميكنيد / آيا خود شما عوايدي داريد؟  اگر جواب خير باشد ( A ) را حلقه نماييد.  اگر بلي، چي كار ميكنيد؟  خارج از منزل كار A .....نميكند..... B صنعت .....دستي..... ..... C دروگري كردن ..... D فروختن .....غذا..... ..... E دوكاندار / دست .....فروشي..... F مزدوركار / كار در خانه ها ..... G كارگر با معاش ..... H .....مالداري..... ..... I قالين .....باقي..... ..... J ----- تاجر قالين ..... X وغيره (مشخص .....شود) .....		
11	وظيفه شوهر تان چيست؟  A بيكار است ..... ..... B دهقاني ميكند ..... ..... C دروگري .....كردن..... ..... D مواد خوراكه .....ميفروشد..... ..... E دكاندار / دست فروشي ..... ..... F خدمه / چوكي .....دار..... ..... G كارگر با معاش ..... ..... H مالداري..... ..... ..... X وغيره (مشخص .....شود) .....		

تمام سوالات ذيل در ارتباط به خورد ترين طفل پانينتراز دو سال پرسیده شود:

	<p>A طفل را باخود</p> <p>.....میرم</p> <p>B شوهرم.....</p> <p>C دختر / پسر کلان</p> <p>.....ام</p> <p>D مادرکلانش</p> <p>.....</p> <p>E عمه یا خاله</p> <p>.....اش.</p> <p>.....</p> <p>F دیگر اقارب</p> <p>.....</p> <p>G همسایه هایم / دوستانم.....</p> <p>.....</p> <p>H خدمه</p> <p>.....</p> <p>I شیر</p> <p>.....خوارگاه.....</p> <p>.....</p> <p>X و غیره : مشخص سازید</p> <p>_____</p>	<p>وقتی که از خانه دور باشید کی از (اسم طفل را بگیرید) مواظبت مینمایند؟</p>	12
<b>صحت مادر</b>			
مراقبت قبل از ولادت			
	<p>بلي ، مصاحبه کننده کارت را دید</p> <p>1 .....</p> <p>فقود گردیده</p> <p>.....</p> <p>2.....</p> <p>هیچ کارت نگرفته است</p> <p>3.....</p> <p>نمیداند</p> <p>.....</p> <p>8.....</p> <p>تعداد دفعاتی را که مادر واکسن شده یادداشت نمایید</p> <p>.....</p>	<p>آیا شما کارت واکسن تی تی دارید؟ اگر بلی ، لطفاً برای نشان بدهید.</p> <p>تعداد دفعاتی را که مادر واکسن شده یادداشت نمایید</p> <p>.....</p>	13
	<p>بلي</p> <p>.....</p> <p>1 .....</p> <p>نخیر</p> <p>.....</p> <p>2 .....</p> <p>نمیداند</p> <p>.....</p> <p>8 .....</p>	<p>قبل از این که ( نام طفل ) جان تولد شود ، برای اینکه طفل تان مصاب هفتک ( شخ مانده گی ) بعد از ولادت نگردد ، آیا کدام واکسن در بازوی خود تان تطبیق نموده اید؟</p>	14
	<p>یکبار</p> <p>.....</p> <p>1 .....</p> <p>دوبار</p> <p>.....</p>	<p>چند بار آن واکسن را برای تان تطبیق نموده اید؟</p>	15

	<p>2 ..... بیشتر از دوبار ..... 3 ..... نمیداند ..... 8 .....</p>		
16	<p>زمانیکه (نام طفل را بگیرید) را در شکم داشتید خود را به کسی نشان دادید؟ اگر بلی : به کی نشان دادید؟ کسی دیگر؟ <b>دریابید شخص معاینه کننده کی بوده است و آنرا یاد داشت نماید.</b></p>	<p>پرسونل مسلکی A داکتر صحت عامه ..... ..... B نرس صحت عامه ..... ..... C قابل صحت عامه ..... ..... D داکتر شخصی ..... ..... اشخاص دیگر E دایه های محل ..... ..... F طبیبان محلی ..... ..... و غیره (مشخص X سازید) ..... هیچ Z کس ..... .....</p>	
17	<p>چند بار برای مراقبت قبل از ولادت مراجعه کردید؟</p>	<p>A یک بار در زمان حاملگی ..... ..... B دوبار در زمان حاملگی ..... ..... C سه بار در زمان حاملگی ..... ..... D بیشتر از سه بار در زمان حاملگی ..... ..... E نمیداند ..... .....</p>	
18	<p>آیا در زمان حاملگی کسی برای تان تابلت های آهن توصیه نمود؟ نمونه تابلت آهن را برایش نشان دهید. اگر بلی، چند دانه؟</p>	<p>گرفته است ----- بلی خیر X..... نگرفته است تعداد تابلت های آهن را که گرفته است یادداشت نمایید. _____</p>	
19	<p>آیا شما کدام کارت مراقبت قبل از ولادت دارید؟</p>	<p>بلی، مصاحبه کننده کارت را دید..... 1 مفقود شده است ..... 2 هیچ گاه کارت نداشته ..... 3</p>	

	<p>اگر بلي، آيا من دیده ميتوانم؟</p> <p>تعداد ملاقات ها و تعداد تابليت هاي توصيه شده آهن را يادداشت نماييد.</p>	<p>نميداند ..... 8.</p> <p>تعداد ويزيت هاي قبل از ولادت _____</p> <p>تعداد تابليت هاي توصيه شده آهن _____</p>
20	<p>چرا شما براي مراقبت قبل از ولادت مراجعه نکرديد؟</p> <p>تماماً جوابات تذكّر يافته را يادداشت نماييد.</p>	<p>A آگاهي نداشتم.....</p> <p>B فاصله زياد بود.....</p> <p>C فاميلم اجازه نداد.....</p> <p>D كسي از فاميل همراهي نكرد.....</p> <p>E مركز صحي موجود نبود.....</p> <p>F در كلينك كسي نبود تامعاينه كنند.....</p> <p>وغيره : مشخص X سازيد_____</p>
21	<p>وقتيكه ( نام طفل ) در شكّم تان بود چقدر غذا ميخورديد؟ بيشتر از حد معمول، کمتر از حد معمول، مثل هميشه.</p>	<p>1 کمتر از حد معمول ..... 2 مثل هميشه ..... 3 بيشتّر از حد معمول .....</p>
22	<p>كدام غذا ها از كم خوني جلوگيري ميكند؟</p> <p>تمام جوابات تذكّر يافته را يادداشت نماييد.</p>	<p>A غذاهاي پروتين دار ( تخم، ماهي، گوشت) .....</p> <p>B سبزيّات داراي برگ سبز ..... .....</p> <p>C وغيره (مشخص سازيد) .....</p> <p>D وغيره (مشخص سازيد) .....</p> <p>E وغيره (مشخص سازيد) .... .....</p> <p>X نميداند _____</p>
23	<p>در زمان حاملگي، چه علايمي باعث خواهد شد تا شما در جستجوي مراقبت صحي شويد؟</p> <p>تماماً جوابات تذكّر يافته را يادداشت نماييد.</p> <p>همچنان تعداد جوابات درست را يادداشت نماييد.</p>	<p>A تب _____ .....</p> <p>B نفس تنگي .....</p> <p>C خونريزي..... .....</p> <p>D پنديده گي روي، دستان و عضويت.....</p>

	و غیره (مشخص X سازید) _____ تعداد جوابات درست _____ Z نمیدانند..... .....	
24	در صورتی که علایم ذکر شده فوق موجود باشد کجا میروید؟ ..... به شفاخانه ..... 11 ..... کلینیک حمایتی طفل و مادر ----- 12 مرکز صحتی اساسی (کلینیک) ..... 13 کلینیک موسسه خارجی ----- 14 کلینیک های سیار ----- 15 به معاینه خانه داکتران شخصی ..... 16 ..... طبیبان محلی ..... ..... 21 ..... و غیره (مشخص سازید) _____ 96	
مراقبت زمان ولادت / نوزاد:		
25	خانۀ خانۀ خودما ..... 11 ..... خانۀ کسی دیگری 12 ..... مرکز صحتی شفاخانه ..... 21 ..... کلینیک حمایتی طفل و مادر ..... 22 ..... کلینیک صحتی اساسی ----- 23 کلینیک موسسه خارجی ----- 24 به معاینه خانه داکتران شخصی ..... 25 ..... و غیره (مشخص سازید) _____ 96	در کجا ولادت نمودید؟
26	A داکتر ..... ..... B نرس ..... ..... C قابل ..... ..... D دایه تربیه شده ..... .....	کی شمارا در ولادت کمک کرد؟

	دایه تربیه ناشده E ..... شوهرم F ..... اقارب تربیه G..... شده ام..... اقارب تربیه ناشده H ..... خودم I ..... نمیدانند J ..... .....		
27	پلجديد ..... 1 ..... ديگر اشيا _____ 2_____	براي قطع کردن ناف نوزاد ازچه استفاده نمودید؟	
28	نزد مادرش ..... 1 ..... روي چپرکت ..... 2 ... بروي زمین بدون روجايي 3..... ديگر جاها : (مشخص سازيد) 6 ..... نمیدانند..... 8 .....	فورآبعداز تولد (اسم طفل را بگيريد) کجا گذاشتید؟	
29	در ظرف يك ساعت A ..... بين دو تا هشت ساعت B ..... بعد از ساعت هشتم روز C ..... بعد از روز اول D .....	(اسم طفل را بگيريد) راجه وقت بعدازتولد همام دادید؟	
مراقبت بعد از ولادت			
30	بلي..... 1 ..... نخير ..... 2 .....	بعداز ولادت (اسم طفل را بگيريد)، آیا کسی صحت شما راچک کرد؟	
31	پرسونل مسلکي 1	کي صحت تان را چک نمود؟	

	دقيقاً دريابيد كي چك نموده است.	داكتړ..... ..... نرس 2 ..... ..... 3 ..... قابلله / ..... ..... اشخاص ديگر دايه هاي محل 4 ..... طبيبان محلي ..... 5. .... ..... وغيره (مشخص 6 ..... سازيد) .....
32	چند روز/ هفته بعد از ولادت اولين بار خود را چك نموديد؟  در صورت كه چك در همان روز صورت گرفته باشد در خانه روز (00) بگذاريد.	ولادت _____ روز بعد از ولادت _____ هفته بعد از نميداند 9_ .....
33	در هنگام چك نمودن شما آيا صحت (اسم طفل را بگريد) نيز چك شد؟	بلي..... 1 ..... نخير ..... 2 .....
34	بعد از تولد ( نام طفل ) جان چند بار صحت شما چك گرديد؟	يك بار دو بار يا بيشتر
35	در ختم ولادت، کدام علام خطر اتفاق افتد تا شما در جستجوي مراقبت صحي گرديد؟  تماماً جوابات تذكر يافته را يادداشت نماييد همچنان تعداد جوابات درست را يادداشت نماييد	تب A ..... ..... خونريزي شديد B ..... ..... خارج شدن مواد بويناك از C مهبل ..... وغيره D ..... ..... وغيره E..... وغيره F ..... ..... تعداد جوابات درست _____ ..... نميداند Z ..... .....
36	كدام علام نزد يك نوزاد نشان دهنده مريضى اش ميباشد؟	تغذي A ..... ضعيف..... .....

	<p>تنفس B سريع ..... ..... بي حرکت بودن (فعال C نبودن) ..... سرخي اطراف D ناف ..... سرخي / افرازات چشم E ..... وغيره (مشخص X سازيد) ..... تعداد جوابات درست ..... Z نميدانم ..... .....</p>	<p>تماماً جوابات تذكر یافته را يادداشت نمایید. همچنان تعداد جوابات درست را يادداشت نمایید.</p>	
37	<p>هنگام مراقبت/معاینه بعد از ولادت درمورد ذیل براینان معلومات داده شد؟  برنامه ریزی خانواده؟ تغذي نوزاد؟ واکسين طفل؟ اسهال نوزاد؟ علامه متقدم سينه بغل؟ تغذي با شیر مادر ؟</p>	<p>بلي تغذي نوزاد واکسين طفل اسهال نوزاد علامه متقدم سينه بغل تغذي با شیر مادر</p>	<p>برنامه ریزی خانواده 1 2 تغذي نوزاد 1 2 واکسين طفل 1 2 اسهال نوزاد 1 2 علامه متقدم سينه بغل 1 2 تغذي با شیر مادر 1 2</p>
<b>B - تغذي با شیر مادر / تغذي طفل</b>			
38	<p>آيا شما (اسم طفل را بگيريد) را گاهي شیر داده ايد؟</p>	<p>بلي ..... 1 ..... تغذي ..... 2 .....</p>	
39	<p>چه مدت بعد از تولد (اسم طفل را بگيريد) را سينه داديد؟</p>	<p>در ظرف يك ساعت ..... 1 ..... در ظرف 8 ساعت اول ..... 2 ..... بعد از 8 ساعت اول ..... 3 ..... بعد از روز اول ..... 4 ..... بخطا نرورد ..... 9 .....</p>	
40	<p>حالا من در باره بعضي از مایعات و غذا ها که براي (نام طفل) جان در 24 ساعت گذشته خورانده ايد میپرسم:</p>		



	خوراند هاید میپرسم : A. شیر مادر ؟ B. آب عادی ؟ C. دیگر مایعات ؟ D. غذا های میده شده و نرم ؟ E. دیگر غذا ها : مشخص سازید ؟	. . A _____ . . B _____ . C _____ . D _____ . E _____ _____ _____ _____ _____ _____ _____
41	آیا برای ( نام طفل ) جان در شش ماه گذشته کدام کپسول ویتامین آ مثل این ( کپسول ویتامین آ را نشان دهید ) داده اید ؟	بلی ..... 1 ..... نخیر ..... 2 ..... نمیدانم ..... 8 .....
42	اجازه است ( نام طفل ) جان را وزن نمایم ؟	بلی ..... 1 ..... نخیر ..... 2 .....
43	اگر مادر قبول میکند ، طفل را وزن نموده و آنرا یادداشت نمایید . صرف یک خانه بعد از اعشاری را یادداشت نمایید .	_____ کیلو گرام
<b>معافیت</b>		
44	( اسم طفل را بگیری ) جان کارت واکسین دارد ؟ اگر بلی باشد : میتوانم ببینم ؟	بلی دیده شد ..... 1 ..... گم شده ..... 2 ..... هیچگاه کارت نگرفته 3 ..... نمیدانم ..... 8 .....
45	تاریخ هر واکسین اجرا شده را از کارت به سوالنامه ثبت نمایید .	_____ ماه / _____ سال / _____ روز بی سی جی / _____ / _____ پولیو صفر / _____ / _____ پولیو 1 / _____

	<div><div><div><div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div></div></div></div></div>
--	---

	<p>چند بار؟</p> <p>واکسین برای وقایه سرخکان؟</p>	<p>2 . . . . .</p> <p>دفعات</p> <p>.....</p> <p>.....</p> <p>بلي.....</p> <p>1 . . . . .</p> <p>نخیر</p> <p>.....</p> <p>2 . . . . .</p> <p>نمیدانند</p> <p>8 . . . . .</p> <p>_____ بار</p> <p>بلي.....</p> <p>1 . . . . .</p> <p>نخیر</p> <p>.....</p> <p>2 . . . . .</p> <p>نمیدانند</p> <p>8 . . . . .</p>
	اهتمامات طفل مريض	
49	<p>بعضي اوقات اطفال مريض میشوند و ضرورت به تداوي میداشته باشند، در صورت بروز کدام علايم شما میدانید که طفل تان ضرورت به تداوي دارد؟</p> <p><b>تماماً جوابات تذکر یافته را حلقه نمایید.</b></p>	<p>A. نمیدانند</p> <p>. مريض معلوم میشود یا مثل B همیشه بازی نمیکند</p> <p>C. خورده یا نوشیده نمیتواند</p> <p>. خواب آلوده یا به مشکل D بیدار شود</p> <p>E. تب بلند</p> <p>F. تنفس سریع یا مشکل</p> <p>G. هر چیز را استفراغ میکند</p> <p>H. شخ مانده گی</p> <p>I. اسهال خوندار</p> <p>. اسهال دوامدار بیشتر از دو J هفته</p> <p>. و غیره</p> <p>K _____</p> <p>. و غیره</p> <p>L _____</p>
50	<p>آیا ( نام طفل ) جان در دو هفته گذشته به یکی از امراض ذیل مصاب شده بود؟</p> <p>نام تمام امراض را بلند بخوانید و آن امراضی را که توسط مادر تایید میگردد حلقه نمایید.</p>	<p>A. اسهال</p> <p>B. خون در مواد غایطه</p> <p>C. سرفه</p> <p>. تنفس سریع / تنفس تیز و D کوتاه</p> <p>E. تب</p> <p>F. ملاریا</p> <p>G. شخ مانده گی</p> <p>. و غیره</p>

	<div>H _____ . وغيره I _____ . وغيره J _____ K. هيچ کدام</div>		
51	وقتیکه ( نام طفل ) جان مريض بود مایعات را برایش کمتر از حد معمول ، بیشتر از آن و یا به اندازه معمول میدادید ؟ 1 کمتر از حد معمول ..... 2 مثل همیشه ..... 3 بیشتر از حد معمول .....		
52	وقتیکه ( نام طفل ) جان مريض بود غذا را برایش کمتر از حد معمول ، بیشتر از آن و یا به اندازه معمول میدادید ؟ 1 کمتر از حد معمول ..... 2 مثل همیشه ..... 3 بیشتر از حد معمول .....		
اسهالات:			
به سوال 50 مراجعه شود، اگر جواب 1 یا 2 باشد سوال 53 را تعقیب کنید، در غیر آن ، به سوال 56 مراجعه کنید.			
53	براي تداوي اسهال ( نام طفل ) جان چي میدید؟ دیگر چي؟ تماماً جوابات تذکر یافته را یادداشت نمایید.	<div>A هيچ چيز ..... ..... B حلول او ار اس ..... ..... C مایعات خانه گي ..... ..... D تابليت يا شربت ..... ..... E پیچکاري ..... ..... F سیروم از رگ ..... ..... G دواهاي خانه گي / يوناني ..... ..... H واهي ضد میکروب ..... ..... X وغيره ( مشخص سازید ) ..... .....</div>	
54	وقتیکه ( اسم طفل را بگیرید ) جان اسهال شده بود، از کي کمک یا تداوي دریافت کردید؟ يکي از جوابات را یادداشت نمایید.	<div>A داکتر صحت عامه ..... ..... B داکتر شخصي ..... ..... C طبیب محلي ..... ..... D دواخانه قريه ..... ..... ..... E خودم ..... ..... .....</div>	

	<p>F دوستان / همسایه</p> <p>.....</p> <p>G..... نمیدانند</p> <p>.....</p>		
55	<p>A او آراس.....</p> <p>.....</p> <p>B سیروم از طریق رگ</p> <p>.....</p> <p>C دواي ضد اسهال</p> <p>.....</p> <p>D دواي ضد میکروب</p> <p>.....</p> <p>E پرهیزانه</p> <p>.....</p> <p>.....</p> <p>X (مشخص سازید)</p>	<p>تماماً جوابات را یادداشت نمایید.</p>	
56	<p>A استفراغات شدید</p> <p>.....</p> <p>.....</p> <p>B اسهال و تب</p> <p>.....</p> <p>C اسهال دوامدار بیشتر از 14 روز</p> <p>.....</p> <p>D اسهال همراه باخون</p> <p>.....</p> <p>E (مشخص سازید)</p> <p>.....</p> <p>F (مشخص سازید)</p> <p>.....</p> <p>G..... (مشخص سازید)</p> <p>..... (مشخص سازید)</p> <p>تعداد جوابات درست _____</p> <p>X ..... نمیدانند</p> <p>.....</p>	<p>در صورتیکه طفل تان اسهال باشد کدام علام خطر شما را مجبور میسازد تا در جستجوی تداوي ومشوره برآید؟</p> <p>تمام جوابات را یادداشت نمایید.</p> <p>تعداد جوابات درست را یادداشت نمایید.</p>	
57	<p>او آراس بصورت درست تهیه شده است..... 1</p> <p>او آراس بصورت نادرست تهیه شده</p>	<p>آیا شما کدام پاکت او آراس در خانه دارید؟</p> <p>اگر بلي، ازمادر بخواهید تا براي تان او آراس تیار نماید.</p> <p>اگر نخیر، يك پاکت او آراس را براي</p>	

	است 2....	<p>مادر بدهید و از او بخواهید تا محلول او آراس را تهیه نماید.</p> <p>زمانیکه عمل تهیه محلول او آراس ختم شد، یادداشت نماید که آیا به صورت درست محلول تهیه شده است یا خیر؟</p> <p>در صورتیکه مادر اجراءات ذیل را نماید غیر (1) را حلقه نماید:</p> <p>از ظرفی پاک که ظرفیت یک لیتر را داشته باشد استفاده نماید.</p> <p>از پاکت مکمل او آراس استفاده نماید</p> <p>در صورتیکه بصورت مکمل حل نماید</p> <p>وقتیکه مادر تهیه محلول را ختم نمود یک پاکت پودر او آراس را برای استفاده آینده اش بدهید.</p>	
58	<p>آیا فامیل شما کدام جای مناسب برای دست شستن دارد؟</p> <p>بلی..... 1 ..... غیر..... 2 .....</p>		
59	<p>محلی را که برای دست شستن استفاده میشود ببینید و ملاحظات ذیل را از نظر بگذرانید.</p> <p>بلی / غیر (1) آب / شیر دهن 1 2</p> <p>(11) صابون، خاکستریا کدام مواد دیگر دست شویی 1 2 (111) طشت 1 2</p>		
60	<p>چه وقت معمولاً دستان را با صابون یا خاکستریشوید؟</p> <p><b>تمام جوابات ذکر شده را یادداشت نماید.</b></p> <p>قبل از تهیه غذا A ..... ..... قبل از خوردن غذا B ..... ..... قبل از تغذی طفل C ..... ..... بعد از رفع حاجت D ..... ..... بعد از رفع حاجت طفل که کمکش نمودم.. E F هرگز نی..... ..... ..... و غیره (مشخص سازید) X</p>		

	.....		
امراض حاد تنفسي			
به سوال 50 مراجعه نماييد. اگر جواب 3، 4 يا 5 باشد سوال 61 را تعقيب نماييد. در غير آن از سوال 65 شروع كنيد.			
61	وقتي كه (اسم طفل را بگريد) جان مريضى همراه با سرفه داشت. آيا او تيز تيز نفس ميكشيد؟ بلي..... 1 ..... خيّر ..... 2 ..... نميدانند ..... 8 .....		
62	آيا شما براي سرفه و تنفس سريع طفل تان تداوي يا مشوره مطالبه كرديد؟ بلي..... 1 ..... خيّر ..... 2 .....		
63	بعد از چه مدت از سرفه و تنفس سريع (اسم طفل را بگريد) جان به تداوي آن شتافتيد؟ همان روز..... 0 ..... فردا ..... آنگاه ..... 1 ..... دو روز ..... بعد ..... 2 ..... سه يا بيشتر از آن ..... 3 ..		
64	از كجا مشوره يا تداوي براي مريضى (اسم طفل را بگريد) جان دريافت كرديد؟ از جاي ديگر؟ تمام اجابات را يادداشت نماييد. شفاخانه ..... 11 ..... كلينيك همايه طفل و مادر ..... 12 ..... مركز صحي ..... 13 ..... كلينيك موسسات خارجي ..... 14 ..... معايينه خانه داکتران شخصي ..... 15 ..... طبيبان محلي ..... 21 ..... وغيره (مشخص سازيد) 96 ..... .....		
فاصله بين ولادت ها			
65	آيا شما ميدانيد كه در كجا بخاطر دريافت ميتودهاي برنامه ريزي فاميلي/ فاصله بين ولادت ها مراجعه نماييد؟ اگر جواب خيّر باشد عدد 99 را حلقه كنيد. اگر جواب بلي باشد (در كجا) ؟ شفاخانه ..... 11 ..... كلينيك همايه طفل و مادر ..... 12 ..... مركز صحي ..... 13 ..... كلينيك موسسات خارجي ..... 14 .....		

	<p>تمام جوابات را یادداشت نمایید.</p>	<p>معاینه خانه داکتران شخصي .....15</p> <p>طبيبان محلي ----- 21</p> <p>وغيره (مشخص سازيد) 96 .....</p> <p>نمیدانند ----- 99</p>
66	<p>آيا شما فعلا حامله استيد؟</p>	<p>بلي.....</p> <p>1</p> <p>خير</p> <p>.....</p> <p>2</p> <p>معلوم</p> <p>نست.....</p> <p>8</p>
67	<p>آيا آرزو داريد كه دردوسال آینده صاحب فرزند شويد؟</p>	<p>بلي.....</p> <p>1</p> <p>خير</p> <p>.....</p> <p>2</p> <p>نمیدانند</p> <p>.....</p> <p>8</p>
68	<p>اگر خير جواب (بدون ميتود ) را حلقه نماييد.</p> <p>جواب درست را حلقه نماييد.</p>	<p>بدون ميتود .....</p> <p>01</p> <p>نورپلانت</p> <p>.....</p> <p>02</p> <p>زريقي</p> <p>.....</p> <p>03</p> <p>تابليت</p> <p>.....</p> <p>04</p> <p>لوپ</p> <p>.....</p> <p>05</p> <p>ميتود بارير/ ديفراگم ----- 06</p> <p>پوقانه ----- 07</p> <p>جل ----- 08</p> <p>بستن نفير ها ----- 09</p> <p>عمليات مرد ----- 10</p> <p>نديدن عادت ماهوار در زمان شير دهی ----- 11</p> <p>به حساب تاريخ عادت ماهوار ----- 12</p> <p>خود داري يا پرهيز ----- 13</p> <p>بيرون ريختن ----- 14</p> <p>وغيره ( مشخص سازيد ) ----- 96</p>



## ايدس و ديگر امراضي تناسلي:

69	آیا شما کدام مرضي را بنام ايدس شنیده ايد؟	بلي ..... 1 ..... ---- خیر ..... 2 .....
70	يك شخص چي کار هاي بکند تا به مرض ايدس مبتلا نگردد؟	خودداري از عمل A جنسي ..... ..... استفاده B از کاندوم ..... ..... وفادار ماندن به يك پارتنر C جنسي ..... محدود کردن تعداد پارتنر هاي D جنسي ..... خودداري از فاحشه ها E ..... ..... خودداري جنسي از کسی F ..... که پارتنر زیاد دارد .. خودداري از عمل G ..... جنسي با همجنس ها خودداري از عمل جنسي با معتادين که ادويه زرقی اخذ میکنند H ..... ..... خودداري از خون گرفتن I ..... ..... خودداري از زرقیات J ..... ..... خودداري از بوسیدن K ..... ..... جلوگیری از گزیدن پشه L ..... ..... حذر از طیبیبان محلي M ..... ..... خودداري استفاده از ماشین وپل N ریش مشترک .. ..... وغيره (مشخص سازید) W ..... ..... وغيره (مشخص سازید) X ..... .....

	Z نمیدانند..... .....		
<u>جلوگیری از ملاریا</u>			
	1 ----- بلي 2 ----- نخیر 8 ----- نمیدانند	آیا شما در خانه تان کدام پشه خانه دارید؟	71
	A ..... (نام طفل) B ..... خودش C ..... (مشخص سازید)	دیشب کي زیر پشه خانه استراحت نموده بود؟ تمام جوابات را یادداشت نمایید.	72
	1 ----- بلي 2 ----- نخیر 8 ----- نمیدانند	آیا گاهی پشه خانه را بخاطر از بین بردن پشه ها دوا زده اید؟	73

**ختم**  
تشکر از اینکه در سروی با ما اشتراک نمودید!

**KNOWLEDGE, PRACTICE AND COVERAGE (KPC) SURVEY.**  
**AFGHANISTAN** **NOVEMBER 2003**

**Informed Consent**

Hello. My name is \_\_\_\_\_, and I am working with Save the Children-US and the MOPH. We are conducting a survey and would appreciate your participation. I would like to ask you about your health and the health of your youngest child under the age of two. This information will help Save the Children and the MOPH to plan health services and assess whether it is meeting its goals to improve children's health. The survey usually takes 45 minutes to complete. Whatever information you provide will be kept strictly confidential and will not be shown to other persons.

Participation in this survey is voluntary and you can choose not to answer any individual questions. However, we hope that you will participate in this survey since your views are important.

At this time, do you want to ask me anything about the survey?

Signature of Respondent: \_\_\_\_\_ Date: \_\_\_\_\_

**RESPONDENT AGREES TO BE INTERVIEWED**

**RESPONDENT DOES NOT AGREE TO BE INTERVIEWED ➔ END**

CLUSTER NUMBER: \_\_\_\_\_ (1-30)  
RECORD NUMBER: \_\_\_\_\_ (001-300)  
DISTRICT: \_\_\_\_\_ NAME OF THE VIALAGE: \_\_\_\_\_  
LANGUAGE: \_\_\_\_\_  
HOUSEHOLD HEAD'S NAME: \_\_\_\_\_

**ALL QUESTIONS ARE TO BE ADDRESSED TO MOTHERS WITH A CHILD LESS THAN 24 MONTHS OF AGE.**

1. INTERVIEW DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(dd/ mm/ yy)
2. INTERVIEWER'S NAME: \_\_\_\_\_
3. NOTETAKER'S NAME: \_\_\_\_\_
4. What is your name? RECORD THE NAME OF THE MOTHER (RESPONDENT): \_\_\_\_\_
5. How old are you? RECORD AGE OF THE MOTHER (RESPONDENT) IN YEARS: \_\_\_\_
6. How many children living in this household are under age five? \_\_\_\_ IF NONE, END THE INTERVIEW NOW.
7. How many of those children are your biological children? \_\_\_\_ IF NONE, END THE INTERVIEW NOW.
8. READ ONE OF THE FOLLOWING QUESTIONS BASED UPON THE MOTHER'S RESPONSE TO QUESTION NUMBER 7

**ONLY 1 CHILD UNDER FIVE:** "What is the name, sex and date of birth of that child?"

**MORE THAN 1 CHILD UNDER FIVE:** "What are the names, sex, and dates of birth of your two youngest children?"

	NAME	SEX	DATE OF BIRTH
1			<u>DD</u> / <u>MM</u> / <u>YY</u>
2			<u>DD</u> / <u>MM</u> / <u>YY</u>

NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
9	Have you ever attended school? IF "NO": CIRCLE 1 [NONE]  IF "YES": What is the highest level of school you have attended?	NONE..... 1 PRIMARY..... 2 SECONDARY..... 3 HIGHER..... 4	
10	Do you work outside of the home to earn money?  IF NO, CIRCLE "A" (NO OUTSIDE WORK)  IF YES, What kind of work do you do?	NO OUTSIDE WORK..... A HANDICRAFTS..... B HARVESTING..... C SELLING FOODS..... D SHOPKEEPER/ STREET VENDOR..... E SERVANT/ HOUSEHOLD WORKER..... F SALARIED WORKER..... G LIVE STOCK..... H CARPET WEAVING..... I  OTHER: _____ X (Specify)	
11	What is your husband's occupation?	DOES NOT WORK..... A AGRICULTURAL PRODUCTS..... B HARVESTING..... C SELLING FOODS..... D SHOPKEEPER/ STREET VENDOR..... E SERVANT/ HOUSEHOLD WORKER..... F SALARIED WORKER..... G LIVE STOCK..... H CARPET MERCHANT..... I  OTHER: _____ X (Specify)	

**ALL SUBSEQUENT QUESTIONS PERTAIN TO THE YOUNGEST CHILD UNDER AGE TWO**

12	Who takes care of (NAME) when you are away from home?	MOTHER (RESPONDENT)..... A HUSBAND..... B OLDER CHILDREN..... C GRANDMOTHER..... D AUNT..... E OTHER RELATIVES FROM OUTSIDE THE HOUSEHOLD..... F NEIGHBORS/ FRIENDS..... G MAID..... H NURSERY SCHOOL..... I  OTHER: _____ X (Specify)	
----	---	---	--

<b>MATERNAL HEALTH CARE:</b>
------------------------------

<b>Pre-natal Care:</b>
------------------------

13	<p>Do you have a TT card?</p> <p>IF YES, Can I please see it?</p> <p>RECORD THE NUMBER OF TT IMMUNIZATIONS RECIEVED.</p>	<p>YES, SEEN BY INTERVIEWER..... 1</p> <p>NOT AVAILABLE.....2</p> <p>NEVER HAD A CARD.....3</p> <p>DON'T KNOW.....8</p> <p><b>RECORD THE NUMBER OF TT IMMUNIZATIONS RECEIVED: _____</b></p>	
14	<p>Before you gave birth to (NAME) did you receive an injection in the arm to prevent the baby from getting tetanus, that is, convulsions after birth?</p>	<p>YES..... 1</p> <p>NO..... 2</p> <p>DON'T KNOW.....8</p>	<p>➡ 16</p> <p>➡ 16</p>
15	<p>How many times did you receive such an injection?</p>	<p><b>ONCE.....1</b></p> <p>TWICE.....2</p> <p>MORE THAN 2 TIMES.....3</p> <p>DON'T KNOW.....8</p>	
16	<p>Did you see anyone for pre-natal care while you were pregnant with (NAME)?</p> <p>IF YES: Whom did you see?</p> <p>Anyone else?</p> <p><b>PROBE FOR THE TYPE OF PERSON AND RECORD ALL PERSONS MENTIONED BY THE MOTHER.</b></p>	<p><b>HEALTH PROFESSIONAL</b></p> <p>MOH DOCTOR..... A</p> <p>MOH NURSE/ MIDWIFE..... B</p> <p>MOH MIDWIFE..... C</p> <p>PVT.DOCTOR.....D</p> <p><b>OTHER PERSON</b></p> <p>TBA..... E</p> <p>TRADITIONAL HEALERS..... F</p> <p>OTHER: _____ X</p> <p>(Specify)</p> <p>NO ONE..... Z</p>	<p>➡ 20</p>
17	<p>How often did you go to receive antenatal care?</p>	<p>ONCE DURING PREGNANCY..... A</p> <p>TWICE DURING PREGNANCY..... B</p> <p>THRICE DURING PREGNANCY..... C</p> <p>MORE THAN THRICE..... D</p> <p>DO NOT KNOW..... E</p>	
18	<p>During your pregnancy, did anyone provide you with iron tablets?</p> <p>SHOW SAMPLE IRON TABLET.</p> <p>If YES, ASK: How many?</p>	<p>YES RECEIVED.....1</p> <p>DID NOT RECEIVE ANY.....2</p> <p>DO NOT KNOW.....3</p> <p><b>RECORD NUMBER OF IRON TABLETS RECEIVED: _____</b></p>	
19	<p>Do you have an antenatal card?</p> <p>IF YES, Can I see it?</p> <p>RECORD THE NUMBER OF VISITS RECORDED AND THE NUMBER OF IRON TABLETS RECEIVED.</p>	<p>YES, SEEN BY INTERVIEWER..... 1</p> <p>NOT AVAILABLE.....2</p> <p>NEVER HAD A CARD.....3</p> <p>DON'T KNOW.....8</p> <p>NUMBER OF ANC VISITS RECORDED _____</p> <p>NUMBER OF IRON TABLETS RECEIVED _____</p>	
20	<p>Why did you not see someone for care during the pregnancy?</p>	<p>WAS NOT AWARE..... A</p>	

	RECORD ALL MENTIONED.	LONG DISTANCE.....B NOT ALLOWED BY FAMILY.....C NO FAMILY MEMBERS TO ACCOMPANY...D HEALTH FACILITY NOT PRESENT.....E NO HEALTH STAFF PRESENT.....F  OTHER: _____X (Specify)	
21	When you were pregnant with (NAME), how much did you eat: more than usual, less than usual or same as usual?	LESS THAN USUAL.....1 SAME AMOUNT.....2 MORE THAN USUAL.....3	
22	Which foods help prevent anemia?  RECORD ALL MENTIONED.	PROTEINS RICH IN IRON (EGGS, FISH, MEAT).....A LEAFY GREEN VEGETABLES.....B OTHER _____C (SPECIFY) OTHER _____D (SPECIFY) OTHER _____E (SPECIFY) DON'T KNOW.....X	
23	What are the symptoms during pregnancy indicating the need to seek health care?  RECORD ALL MENTIONED.  ALSO, RECORD THE NUMBER OF CORRECT ANSWERS.	FEVER.....A SHORTNESS OF BREATH.....B BLEEDING.....C SWELLING OF FACE/BODY/HANDS....D  OTHER: _____X (Specify)  NUMBER OF CORRECT ANSWERS: _____  DO NOT KNOW.....Z	➔ 25
24	Where would you go for care if you had these symptoms?	HOSPITAL.....11 MCH CLINIC.....12 BHC.....13 NGO CLINIC.....14 MOBILE CLINIC.....15 CLINICS OF PVT.PRACTITIONERS.....16  TRADITIONAL PRACTITIONER.....17  OTHER: _____96 (Specify)	
<b>Delivery/ Immediate Newborn Care:</b>			
25	Where did you give birth?	HOME YOUR HOME.....11 OTHER HOME.....12  HEALTH FACILITY HOSPITAL.....21 MCH CLINIC.....22 BHC.....23 NGO CLINIC.....24 CLINIC OF PVT. DOCTOR.....25	

		OTHER: _____ 96 (Specify)	
26	Who assisted you with the delivery?	DOCTOR..... A NURSE..... B MIDWIFE..... C TRAINED TBA..... D UNTRAINED TBA..... E HUSBAND..... F TRAINED RELATIVE..... G UNTRAINED RELATIVE..... H HERSELF..... I DON'T KNOW..... J	
27	What instrument was used to cut the cord?	NEW RAZOR BLADE..... 1 OTHER INSTRUMENT: _____ 2 (SPECIFY)	
28	Where was (NAME) put immediately after birth?	WITH MOTHER..... 1 IN COT..... 2 ON FLOOR..... 3  OTHER: _____ 6 (SPECIFY)  DON'T KNOW..... 8	
29	When was the baby first bathed after the delivery?	WITHIN ONE HOUR..... A HOURS TWO THROUGH EIGHT..... B AFTER HOUR EIGHT OF THE FIRST DAY... C AFTER THE FIRST DAY..... D	
	<b>Postpartum Period:</b>		
30	After (NAME) was born, did anyone check on your health?	YES..... 1 NO..... 2	➡ 35
31	Who checked on your health at that time?  <b>PROBE FOR MOST QUALIFIED PERSON.</b>	<b>HEALTH PROFESSIONAL</b> DOCTOR..... 1 NURSE/ MIDWIFE..... 2 MIDWIFE..... 3  <b>OTHER PERSON</b> TBA..... 4 TRADITIONAL HEALER..... 5  OTHER: _____ 6 (Specify) 9 means don't know	
32	How many days or weeks after the delivery did the first check take place?  RECORD '0' DAYS IF SAME DAY.	DAYS AFTER DELIVERY _____ WEEKS AFTER DELIVERY _____  DON'T KNOW..... 999	
33	At that time, did the person check on (NAME)'s health as well?	YES..... 1 NO..... 2	
34	How many times was your health checked after the birth of (NAME)?	WRITE NUMBER OF TIMES: _____ 99= don't remember	
35	What are the signs of danger after giving birth indicating the	FEVER..... A	





40	<p><i>Now I would like to ask you about the types of liquids and foods (NAME) consumed yesterday during the day or at night. Did (NAME) have.....</i></p> <p>READ EACH OF THE FOLLOWING AND PLACE A CHECKMARK IN THE BOX NEXT TO EACH ITEM CONSUMED.</p> <p>A. Breast milk B. Plain water? C. Other liquids? D. Mashed, pureed, solid or semisolid foods? E. Anything else? SPECIFY:</p>	<p><b>CONSUMED IN LAST 24 HOURS</b></p> <p>A. _____ B. _____ C. _____ D. _____ E. _____ _____ _____ _____ _____</p>	
41	<p>Did (NAME) receive a vitamin A dose like this during the last 6 months? SHOW THE AMPULE/CAPSULE/SYRUP.</p>	<p>YES..... 1 NO..... 2 DON'T KNOW.....8</p>	
42	<p>May I weigh (NAME)?</p>	<p>YES.....1 NO.....2</p>	➡ 44
43	<p><i>IF MOTHER AGREES, WEIGH THE CHILD AND RECORD THE WEIGHT. RECORD TO THE NEAREST TENTH.</i></p>	<p>___ . ___ KILOGRAMS</p>	
<b>Immunization:</b>			
44	<p>Do you have a card where (NAME's) vaccinations are written down? IF YES: May I see it please?</p>	<p>YES, SEEN BY INTERVIEWER..... 1 NOT AVAILABLE.....2 NEVER HAD A CARD.....3 DON'T KNOW.....8</p>	<p>➡ 47 ➡ 47 ➡ 47</p>
45	<p>COPY VACCINATION DATE FOR EACH VACCINE FROM THE CARD.</p>	<p><b><u>DAY</u>    <u>MONTH</u>    <u>YEAR</u></b></p> <p>____/____/____ BCG ____/____/____ Polio 0 ____/____/____ Polio 1 ____/____/____ Polio 2 ____/____/____ Polio 3 ____/____/____ DPT 1 ____/____/____ DPT 2 ____/____/____ DPT 3 ____/____/____ Measles</p>	
46	<p>Has (NAME) received any vaccinations that are not recorded on this card, including vaccinations received in a national immunization day campaign?</p> <p>RECORD 'YES' ONLY IF RESPONDENT MENTIONS BCG, POLIO 0-3, DPT 1-3, AND/OR MEASLES VACCINE(S).</p>	<p>YES..... 1 NO..... 2 DON'T KNOW..... 8</p>	
47	<p>Did (NAME) ever receive any vaccinations to prevent him/her from getting diseases, including vaccinations received in a national immunization day campaign?</p>	<p>YES..... 1 NO..... 2 DON'T KNOW..... 8</p>	<p>➡ 49 ➡ 49</p>
48	<p>Please tell me if (NAME) received any of the following vaccinations.</p>		

	<p>48A- A BCG vaccination against tuberculosis, that is, an injection in the arm or shoulder that usually causes a scar?</p> <p>48B- Polio vaccine, that is, drops in the mouth?</p> <p>48C- When was the first polio vaccine received, just after birth or later?</p> <p>48D- How many times was the polio vaccine received?</p> <p>48E- DPT vaccination, that is, an injection given in the thigh or buttocks, sometimes at the same time as polio drops?</p> <p>48F- How many times?</p> <p>48G- An injection to prevent measles?</p>	<p>YES..... 1 NO..... 2 DON'T KNOW..... 8</p> <p>YES..... 1 NO..... 2 DON'T KNOW..... 8</p> <p>JUST AFTER BIRTH..... 1 LATER..... 2</p> <p>NUMBER OF TIMES _____</p> <p>YES..... 1 NO..... 2 DON'T KNOW..... 8</p> <p>NUMBER OF TIMES _____</p> <p>YES..... 1 NO..... 2 DON'T KNOW..... 8</p>	<p>➡48E ➡48E</p> <p>➡48G ➡48G</p>
<b>Care of the Sick Child:</b>			
49	<p>Sometimes children get sick and need to receive care or treatment for illnesses. What are the signs of illness that would indicate your child needs treatment?</p> <p>DO NOT PROMPT. CIRCLE ALL MENTIONED.</p>	<p>A. DON'T KNOW B. LOOKS UNWELL OR NOT PLAYING NORMALLY C. NOT EATING OR DRINKING D. LETHARGIC OR DIFFICULT TO WAKE E. HIGH FEVER F. FAST OR DIFFICULT BREATHING G. VOMITS EVERYTHING H. CONVULSIONS I. BLOODY DIARRHEA J. DIARRHEA LASTING OVER 2 WEEKS K. OTHER _____ (SPECIFY) L. OTHER _____ (SPECIFY)</p>	
50	<p>Did (NAME) experience any of the following in the past two weeks?</p> <p>READ CHOICES ALOUD AND CIRCLE ALL MENTIONED BY RESPONDENT.</p>	<p>A. Diarrhea B. Blood in stool C. Cough D. Fast Breathing/Short, quick breaths E. Fever F. Malaria G. Convulsions H. OTHER _____ (SPECIFY) I. NONE OF THE ABOVE</p>	➡ 56
51	When (NAME) was sick, was s/he offered less than usual to <u>drink</u> , about the same amount, or more than usual to drink?	<p>1. LESS THAN USUAL 2. SAME AMOUNT</p>	

		3. MORE THAN USUAL	
52	When (NAME) was sick, was s/he offered less than usual to eat, about the same amount, or more than usual to eat?	1. LESS THAN USUAL 2. SAME AMOUNT 3. MORE THAN USUAL	
<b>Diarrhea:</b>			
<b>REFER TO QUESTION 50. IF THE ANSWER WAS EITHER 'A' OR 'B' THEN PROCEED TO QUESTION 53. IF NOT, SKIP TO QUESTION 56.</b>			
53	What did you provide to (NAME) to treat the diarrhea?  Anything else?  <b>RECORD ALL MENTIONED.</b>	NOTHING.....A FLUID FROM ORS PACKET.....B HOMEMADE FLUID.....C PILL OR SYRUP.....D INJECTION.....E (IV) INTRAVENOUS.....F HOME REMEDIES/HERBAL MEDICINES....G ANTIBIOTICS FROM SHOPKEEPERS.....H OTHER: _____ X (SPECIFY)	
54	When (NAME) suffered from diarrhea, from whom did you seek advice or treatment?  <b>SELECT ONLY ONE RESPONSE.</b>	GOVT. HEALTH FACILITY STAFF..... A PRIVATE PRACTITIONERS..... B TRADITIONAL HEALERS..... C VILLAGE PHARMACY.....D SELF.....E FRIEND/NEIGHBOR.....F DON'T KNOW..... G	
55	What type of treatment was provided to your child, by the (above mentioned) health care provider?  <b>RECORD ALL MENTIONED</b>	ORS ..... A (I.V) INTRAVENOUS FLUIDS..... B ANTI-DIARRHEAL DRUGS..... C ANTIBIOTIC..... D RESTRICTED DIET..... E  OTHER: _____ X (Specify)	
56	What signs and symptoms would cause you to seek advice or treatment for (name of the child)'s diarrhea?  <b>RECORD ALL RESPONSES.</b>  <b>RECORD NUMBER OF CORRECT RESPONSES.</b>	SEVERE VOMITING.....A FEVER WITH DIARRHEA.....B DIARRHEA LASTING OVER 14 DAYS....C BLOODY DIARRHEA.....D OTHER: _____E (SPECIFY) OTHER: _____F (SPECIFY)  <b>NUMBER OF CORRECT RESPONSES: __</b>  DOES NOT KNOW.....X KNOWS : _____ signs	

57	<p>Do you have any ORS packets in the house?</p> <p>IF YES, ASK MOTHER TO PREPARE ORS FOR YOU. IF NO, PROVIDE MOTHER WITH A PACKET AND ASK HER TO PREPARE THE ORS FOR YOU.</p> <p>ONCE MOTHER HAS COMPLETED PREPARATION, RECORD WHETHER PREPARED CORRECTLY OR NOT.</p> <p>CIRCLE "1" [CORRECTLY] IF THE MOTHER DID THE FOLLOWING:</p> <ul style="list-style-type: none"> <li>USED 1 LITER OF CLEAN DRINKING WATER</li> <li>USED THE ENTIRE PACKET</li> <li>DISSOLVED THE POWDER FULLY</li> </ul> <p>WHEN THE MOTHER HAS FINISHED PREPARING THE SOLUTION, GIVE HER AN ORS PACKET TO KEEP FOR FUTURE USE.</p>	<p>ORS PREPARED CORRECTLY..... 1</p> <p>ORS PREPARED INCORRECTLY..... 2</p>													
58	Does your household have a special place for hand washing?	<p>YES..... 1</p> <p>NO..... 2</p>	➔ 60												
59	ASK TO SEE THE PLACE USED MOST OFTEN FOR HAND WASHING AND OBSERVE IF EACH OF THE FOLLOWING ITEMS ARE PRESENT.	<table border="0"> <thead> <tr> <th></th> <th>YES</th> <th>NO</th> </tr> </thead> <tbody> <tr> <td>(I) WATER/TAP</td> <td>1</td> <td>2</td> </tr> <tr> <td>(II) SOAP, ASH OR OTHER CLEANSING AGENT</td> <td>1</td> <td>2</td> </tr> <tr> <td>(III) BASIN</td> <td>1</td> <td>2</td> </tr> </tbody> </table>		YES	NO	(I) WATER/TAP	1	2	(II) SOAP, ASH OR OTHER CLEANSING AGENT	1	2	(III) BASIN	1	2	
	YES	NO													
(I) WATER/TAP	1	2													
(II) SOAP, ASH OR OTHER CLEANSING AGENT	1	2													
(III) BASIN	1	2													
60	<p>When do you usually wash your hands with soap or ash?</p> <p><b>RECORD ALL MENTIONED.</b></p>	<p>BEFORE FOOD PREPARATION..... A</p> <p>BEFORE EATING..... B</p> <p>BEFORE FEEDING CHILDREN..... C</p> <p>AFTER DEFECACTION..... D</p> <p>AFTER ATTENDING TO A CHILD WHO HAS DEFECCATED..... E</p> <p>NEVER..... F</p> <p>OTHER:..... X (Specify)</p>													
<p><b>Acute Respiratory Infections (ARI):</b></p> <p><b>REFER TO QUESTION 50. IF THE ANSWER WAS 'C', 'D' OR 'E' THEN PROCEED TO QUESTION 61. IF NOT, SKIP TO QUESTION 65.</b></p>															
61	When (NAME) had an illness with a cough, did he/she breathe faster than usual with short, fast breaths?	<p>YES..... 1</p> <p>NO..... 2</p> <p>DON'T KNOW..... 8</p>	➔ 65 ➔ 65												
62	Did you seek advice or treatment for the cough/ fast breathing?	<p>YES..... 1</p> <p>NO..... 2</p>	➔ 65												
63	How long after you noticed (NAME'S) cough and fast breathing did you seek treatment?	<p>SAME DAY..... 0</p> <p>NEXT DAY..... 1</p> <p>TWO DAYS..... 2</p> <p>THREE OR MORE DAYS..... 3</p>													
64	<p>Where did you seek advice or treatment?</p> <p>Anywhere else?</p> <p><b>RECORD ALL MENTIONED.</b></p>	<p>HOSPITAL..... 11</p> <p>MCH CLINIC..... 12</p> <p>BHC..... 13</p> <p>NGO CLINIC..... 14</p> <p>PVT.DOCTORS/CLINICS. .... 15</p> <p>TRADITIONAL PRACTITIONER..... 16</p>													

		OTHER:.....96 (Specify)	
<b>Child Spacing:</b>			
65	<p>Do you know of a place where you could obtain a method of family planning?</p> <p>IF NO, CIRCLE "99" [DON'T KNOW] IF YES, ASK "Where is that?"</p> <p>RECORD ALL MENTIONED.</p>	<p>HOSPITAL..... 11 MCH CLINIC..... 12 BHC.....13 NGO CLINIC.....14 PVT.DOCTORS.....15 TRADITIONAL PRACTITIONER.....21</p> <p>OTHER:.....96 (Specify)</p> <p>DON'T KNOW.....99</p>	
66	Are you currently pregnant?	<p>YES..... 1 NO..... 2 UNSURE..... 8</p>	➡ 69
67	Do you want to have another child in the next 2 years?	<p>YES..... 1 NO..... 2 DON'T KNOW..... 8</p>	➡ 69
68	<p>Are you currently doing something or using any method to delay or avoid getting pregnant?</p> <p>IF NO, CIRCLE '01' [NO METHOD]</p> <p>IF YES, ASK "What is the main method you or your husband/partner are using now to avoid/postpone getting pregnant?"</p> <p><b>CIRCLE THE APPROPRIATE RESPONSES.</b></p>	<p>NO METHOD..... 01</p> <p>NORPLANT..... 02 INJECTIONS..... 03 PILL..... 04 IUD..... 05 BARRIER METHOD/DIAPHRAM... 06 CONDOM..... 07 FOAM/GEL..... 08 TUBAL LIGATION..... 09 VASECTOMY..... 10 LACTATIONAL AMENORRHOEA. 11 RHYTHM..... 12 ABSTINENCE..... 13 WITHDRAWAL..... 14</p> <p>OTHER:..... 96 (Specify)</p>	
<b>HIV &amp; Other STDs:</b>			
69	Have you ever heard of an illness called AIDS?	<p>YES..... 1 NO..... 2</p>	➡ 71
70	<p>What can a person do to avoid getting AIDS or the virus that causes AIDS?</p> <p>Anything else?</p> <p><b>RECORD ALL MENTIONED.</b></p>	<p>ABSTAIN FROM SEX..... A USE CONDOMS..... B LIMIT SEX TO ONE PARTNER/ STAY FAITHFUL TO ONE PARTNER..... C LIMIT NUMBER OF SEXUAL PARTNERS.....D AVOID SEX WITH PROSTITUTES..... E AVOID SEX WITH PERSONS WHO HAVE MANY PARTNERS..... F AVOID INTERCOURSE WITH PERSONS OF THE SAME SEX..... G AVOID SEX WITH PERSONS WHO INJECT DRUGS INTRAVENOUSLY ....H AVOID BLOOD TRANSFUSIONS ..... I AVOID INJECTIONS..... J AVOID KISSING..... K</p>	

		AVOID MOSQUITO BITES..... L SEEK PROTECTION FROM TRADITIONAL HEALER..... M AVOID SHARING RAZORS, BLADES.... N  OTHER:..... W (Specify) OTHER:..... X DON'T KNOW..... Z															
<b>Malaria Prevention</b>																	
71	Do you have any bednets in your house?	YES..... 1 NO..... 2 DON'T KNOW..... 8	➡END ➡END														
72	Who slept under a bednet last night?  <b>CIRCLE ALL THE APPLY.</b>	A. CHILD (name) B. RESPONDENT C. OTHER INDIVIDUAL(S):..... (SPECIFY)															
73	Was the bednet ever soaked or dipped in a liquid to repel mosquitoes or bugs?	YES..... 1 NO..... 2 DON'T KNOW..... 8															
<b>Health Contacts and Sources of Information</b>																	
74	Where do you get general information or advice on health or nutrition?  <b>RECORD ALL MENTIONED.</b>	FORMAL NETWORK DOCTOR..... 1 NURSE/ MIDWIFE..... 2 TRAINERS/HEALTH EDUCATOR ..... 3 CHC MEMBER..... 4 CHWS/TRAINED BIRTH ATTENDANT...5  OTHER:..... 96 (Specify)															
75	In the past month, have you received any health messages from the following?  RADIO  NEWSPAPER  TELEVISION  HEALTH EDUCATOR (CHWS)  CHC MEMBER  EPI CAMPAIGNS	<table border="1"> <thead> <tr> <th><u>YES</u></th><th><u>NO</u></th></tr> </thead> <tbody> <tr> <td>1</td><td>2</td></tr> <tr> <td>1</td><td>2</td></tr> <tr> <td>1</td><td>2</td></tr> <tr> <td>1</td><td>2</td></tr> <tr> <td>1</td><td>2</td></tr> <tr> <td>1</td><td>2</td></tr> </tbody> </table>	<u>YES</u>	<u>NO</u>	1	2	1	2	1	2	1	2	1	2	1	2	
<u>YES</u>	<u>NO</u>																
1	2																
1	2																
1	2																
1	2																
1	2																
1	2																
Thank you for taking the time to meet with me and answer these questions. The information you provided will be kept strictly confidential and will not be shared with any other person.																	

**ATTACHMENT B**  
**FORMULAS FOR THE KPC SURVEY**

Indicator # 1

COMMAND	VARIABLES	NOTES
FREQ	NUMTT13	Identifies how many mothers had 2 or more TTs by card (21+14+5+4 = 44). $44/300 = 15\%$ .
FREQ	TIMEINJ15	Identifies how many mothers recall receiving 2 or more TTs (30+42). $72/300 = 24\%$ .

Indicator # 3

COMMAND	VARIABLES	NOTES
SELECT	AGECHLD > 11	
FREQ	AGECHLD	Identifies number of children between 12 and 23 months for the denominator = 142.
SELECT	BCG > 1/1/95	This series of commands removes all of the children who have not received these vaccinations.
SELECT	OPV0 > 1/1/95	
SELECT	OPV3 > 1/1/95	
SELECT	DPT3 > 1/1/95	
SELECT	MESLES > 1/1/95	
FREQ	AGECHLD	Provides the numerator. $6/142 = 4\%$

Indicator # 5

COMMAND	VARIABLES	NOTES
SELECT	AGECHLD > 11	
FREQ	AGECHLD	Identifies number of children between 12 and 23 months for the denominator = 142.
FREQ	MESLES	Provides the numerator. $17/142 = 12\%$

Indicator # 7

COMMAND	VARIABLES	NOTES
FREQ	VITA41	Provides the numerator (208) and the denominator (300). $208/300 = 69\%$

Indicator # 9

COMMAND	VARIABLES	NOTES
SELECT	NOABOV50 = "N"	
FREQ	NOABOV50	This provides the denominator (205).
SELECT	EAT52 = "2" OR EAT52 = "3"	
SELECT	DRINK51 = "3"	
FREQ	DRINK51	This provides the numerator (14). $14/205 = 7\%$

## Indicator # 10

COMMAND	VARIABLES	NOTES
SELECT	FOOD60 = "Y"	
SELECT	FEED60 = "Y"	
SELECT	DEFEC60 = "Y"	
SELECT	ATTEND60 = "Y"	
FREQ	ATTEND60	This command provides the numerator (50). The denominator should be the total number of survey respondents (300). Therefore, $50/300 = 17\%$ .

## Indicator # 12

COMMAND	VARIABLES	NOTES
FREQ	ASSIST26	This provides the numerator (A = 20 doctors; B = 2 nurses; C = 40 midwives; and D = 22 trained birth attendants for a total of 84 deliveries). The denominator should be the total number of survey respondents (300). Therefore, $84/300 = 28\%$ .

## Indicator # 13

COMMAND	VARIABLES	NOTES
FREQ	PNCCHK30	This provides the numerator (87) and the denominator (300). $87/300 = 29\%$ .

## Indicator # 14

COMMAND	VARIABLES	NOTES
FREQ	NEXT67	Add the value for option 2 'mothers who do not want another child' (115) and option 8 'mothers who are not sure whether they want another child' (7) to find the denominator (122).
FREQ	FP68	Add together options 2-10 ( $2+10+7+1+0+1+0+0+0$ ) to find the numerator of 21. $21/122 = 17\%$

## Indicator # 20

COMMAND	VARIABLES	NOTES
SELECT	DNK49 = "N"	
F4		Count manually to find the numerator (43). The denominator should be the total number of respondents (300). Therefore, $43/300 = 14\%$ .

## Indicator # 21

COMMAND	VARIABLES	NOTES
FREQ	KNOWS35	This will provide the numerator ( $77+10 = 87$ ) and the denominator (300). Therefore, $87/300 = 29\%$ .



## **ANNEX 2. REPORT OF BASELINE ASSESSMENTS**

### **C. IFHA Report: Andkhoy Cluster**

*Provincial Strengthening in Northern Afghanistan:  
Capacity Building and Innovation to Support Afghanistan's Basic Package of  
Health Services and Sustainably Improve Access, Quality and Use of Essential  
MCH Services throughout Jawzjan Province*

Cooperative Agreement No. GHS-A-00-03-00011-00  
September 30, 2003 - September 30, 2008

## **Afghanistan CS-19 IHFA Report Andkhoy, Afghanistan**

Prepared by

Save the Children/US

January 2004

## TABLE OF CONTENTS

### Acronym List

I.	Findings.....	4
A.	Project Indicators.....	4
B.	Observation Checklist – Sick Child.....	5
C.	Exit Interview – Sick Child .....	8
D.	Health Worker Interview.....	11
E.	Equipment and Supplies Checklist.....	14
II.	Summary Conclusions and Recommendations.....	17
III.	Attachments	
A.	Questionnaire in Dari and English	
B.	EPI INFO 6.04 Formulas for Calculating Program IHFA Indicators	
C.	List of Survey Participants	

## ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ARI	Acute Respiratory Infection
BCG	Bacille Calmette-Guerin
BHC	Basic Health Center
C	Celsius
CDD	Control of Diarrheal Disease
CFR	Case Fatality Rate
CHC	Community Health Committee
CHW	Community Health Worker
CS	Child Survival
DIP	Detailed Implementation Plan
DPT	Diphtheria Pertusis Tetanus
EPI	Expanded Program of Immunizations
FGD	Focus Group Discussion
FP	Family Planning
HFA	Health Facility Assessment (Interchangeable with IHFA)
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
IEC	Information, Education and Communication
IHFA	Integrated Health Facility Assessment (Interchangeable with HFA)
IUD	Intrauterine Device
IV	Intravenous
KPC	Knowledge Practice and Coverage (Survey)
LAM	Lactational Amenorrhea Method
MCH	Maternal Child Health
MOH	Ministry of Health
NGO	Non Governmental Organization
OPV	Oral Polio Vaccine
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
SC	Save the Children
TBA	Traditional Birth Attendant
TT	Tetanus Toxoid
VITA	Vitamin A
WRA	Women of Reproductive Age

## I. FINDINGS

### A. PROJECT INDICATORS

The following table presents the 1999 and 2003 baseline rates for the project's ten IHFA-related indicators.

#	CS-19 EOP Indicators	Baseline 1999	Results/ Baseline 2003	Data Source/Notes
24	80% of severely ill <5's classified correctly in CS-19-supported facilities (HFA#14, needs clinical validation).	34.2%	50% (4/8)	ANDOBS03.REC
25	80% of <5 pneumonia cases treated correctly in CS-19-supported facilities (clinical validation during survey).	42%	50% (12/24)	ANDOBS03.REC
26	80% of <5 diarrhea cases treated correctly in CS-19-supported facilities (clinical validation during survey).	66.6%	60% (6/10)	ANDOBS03.REC
27	60% of caretakers of <5's receiving oral drugs know how to administer all essential drugs at home (HFA #25).	32.4%	67% (24/36)	ANDEXT03.REC
28	60% of caretakers of <5's know at least 2 aspects of home care (Exit interview - BASICS HFA indicator #26).	75%	87% (39/45)	ANDEXT03.REC
29	60% of caretakers of <5's know at least 2 signs of when to return if child gets worse (BASICS HFA indicator #27).	67.5%	96% (43/45)	ANDEXT03.REC
30	10% of CS-19 supported facilities had 1/more stock-out of ORS or essential drugs last month (HFA indicator #28).	75%	100% (4/4)	ANDEQP03.REC
31	90% of CS-19-supported facilities achieve perfect EPI quality index score.			
32	% of CS-19 supported facilities achieving ____ MNC quality index score.			
33	100% of BHCs have FP-trained female health worker posted & 3 birth spacing methods in stock.	Not covered in the 1999 Questionnaire	75% (3/4)	ANDEQP03.REC

The findings presented here are from the December 2003 surveys and follow the general format of the assessment tool used, the USAID/BASICS Integrated Health Facility Assessment (IHFA), which is in four components:

1. Observation Checklist – Sick Child
2. Exit Interview – Sick Child
3. Health Care Worker Interview
4. Equipment and Supplies Checklist

Comparisons between the 1999 and 2003 results are summarized in the section, Conclusions and Recommendations later in this report.

## B. OBSERVATION CHECKLIST – THE SICK CHILD

This questionnaire focuses on assessment of health worker skills in diagnosis, medication, treatment, and health education for care of the sick child. The examinations of 46 infants and children under the age of five years who presented at health facilities with fever/malaria, cough/difficulty breathing/pneumonia, or diarrhea/vomiting were observed between December 6 – 8, 2003. This care was provided by four physicians working at three basic health centers (BHC) and one maternal child health (MCH) clinic.

Of the 46 children brought to these health facilities, 76% (35/46) were experiencing difficulty breathing/cough/pneumonia, 57% (26/46) were experiencing diarrhea/vomiting, and 50% (23/46) had fevers. In the examinations, the health workers were observed as they assessed the sick child. Forty-one percent (19/46) of children had all four initial assessment tasks done.

Completion of Initial Assessment Tasks	Frequency (N = 46)	Percent
Ask the age of the child	44	96%
Weighs the child	31	67%
Plots the child's weight on growth chart	28	61%
Checks temperature	33	72%

The health workers were then observed to see whether they checked for or asked about the most common danger signs:

Health Worker Assessment of Danger Signs	Frequency (N = 46)	Percent
Not able to drink or breastfeed	43	93%
Vomits everything	38	83%
Change in consciousness/ lethargic/sleepy	38	83%
Convulsions	33	72%

In total, 57% (26/46) of caretakers were asked about all four danger signs by the health worker and 72% (33/46) were asked about all four of the primary ailments – diarrhea, ARI, fever and ear problems.

Specific to diarrhea, 89% (41/46) of caregivers were questioned about whether the child had diarrhea. Of these, 59% (24/41) were asked whether there was blood in the stool and 56% (23/41) were asked about the duration of the diarrhea. With regard to diarrhea-related examination tasks, 67% (31/46) of children had their eyes checked to see whether they were sunken, 63% (29/46) had their skin pinched on the abdomen, and 50% (23/46) were observed drinking or breastfeeding. In sum, out of a total of five history and examination tasks used for assessing diarrhea and dehydration, health workers successfully completed the following:

<b>Number of Diarrhea-Related Assessment Tasks Completed Per Sick Child</b>	<b>Frequency (N = 46)</b>	<b>Percent</b>
0	7	15%
1	5	10%
2	4	9%
3	9	20%
4	15	33%
5	6	13%
<b>Total</b>	<b>46</b>	<b>100%</b>

Eighty-nine percent (41/46) of caregivers were asked whether the child had a cough or difficult breathing and of these, 71% (29/41) were asked about the duration of these symptoms. Eighty-seven percent (40/46) of these children had their shirt raised so the chest could be examined; 76% (35/46) were checked for chest indrawing; and 67% (31/46) had their breaths counted. Health workers successfully completed the following number of assessment tasks related to the diagnosis for pneumonia and other acute respiratory infections:

<b>Number of ARI-Related Assessment Tasks Completed Per Sick Child</b>	<b>Frequency (N = 46)</b>	<b>Percent</b>
0	5	11%
1	4	9%
2	2	4%
3	14	30%
4	21	46%
<b>Total</b>	<b>46</b>	<b>100%</b>

Ninety-one percent (42/46) of caregivers were asked whether the child had a fever and of these, 62% (26/42) were asked about its duration. Sixty-seven percent (31/46) of the children were checked for a stiff neck, 61% (28/46) for a generalized rash, and 59% (27/46) for a runny nose or red eyes. Health workers successfully completed the following number of assessment tasks related to fever:

<b>Number of Fever-Related Assessment Tasks Completed Per Sick Child</b>	<b>Frequency (N = 46)</b>	<b>Percent</b>
0	8	17%
1	3	7%
2	8	17%
3	15	33%
4	12	26%
<b>Total</b>	<b>46</b>	<b>100%</b>

With regard to malnutrition, 76% (35/46) of children had both their feet checked for edema, 65% (30/46) were undressed and checked for wasting, and 59% (27/46) were checked for palmer or conjunctive pallor. Also taking into account the children who were weighed and had their weight plotted on a growth chart, 15% (7/46) of the children were correctly assessed for malnutrition.

Each of the children's caregivers (100% or 46/46) was asked for the child's immunization card and 91% (42/46) had cards. Twenty-eight percent (13/46) of the children were found to be up to date based on the health workers' review of cards; 41% (19/46) of the children received at least one immunization that day; 7% (3/46) of the children were referred to come back another day; and 22% (10/46) were not referred.

Ninety-three percent (43/46) of caregivers were asked whether they had their own immunization card and 84% (36/43) had their cards. Thirty percent (14/46) were considered up to date based on a review of the cards; 30% received an immunization the day of the visit; 22% (10/46) were referred to return another day for an immunization; and 26% (12/46) were not referred.

Each child was also examined by Save the Children validators to assess the accuracy of the health worker's classification of the illness and were in agreement with the health workers' diagnosis 67% (31/46) of the time. The health workers identified a total of 54 ailments in these children, of which the validators agreed with 69% (37/54) of the diagnosis as noted below:

	Total Number of Diagnosis Made by Health Workers (N)	Agreement on Diagnosis Between Health Workers and Validators	
		Frequency	Percentage
Upper respiratory infection (cough/cold)	16	7	44%
Simple diarrhea <sup>13</sup>	9	7	78%
Pneumonia	8	7	88%
Acute ear infection	7	4	57%
Dysentery	6	5	83%
Chronic Ear Infection	4	4	100%
Other fever	1	0	0%
Severe malnutrition	1	1	100%
Moderate malnutrition/anemia	1	1	100%
Persistent diarrhea	1	1	100%
<b>Total</b>	<b>54</b>	<b>37</b>	<b>69%</b>

The validators agreed with the health workers 72% (33/46) of the time in the medicines they prescribed and 57% (26/46) of the time in the overall treatment they provided.

<sup>13</sup> Of the nine children diagnosed with simple diarrhea, five were considered to have no dehydration and the other four children with diarrhea were not assessed for dehydration.

Appropriateness of Medication and Treatment per Diagnosis	Appropriate Medicine Provided		Proper Treatment Provided	
	Frequency	Percent	Frequency	Percent
Diarrhea	7/10	70%	6/10	60%
Pneumonia	14/24	58%	12/24	50%
Dysentery	6/6	100%	5/6	83%

Eighty-five percent (39/46) of health workers explained how to administer medicines/ORS and 54% (25/46) demonstrated how to correctly provide the medicines/ORS. Fifty-two percent (24/46) of health workers asked open-ended questions to verify that the caregivers understood how to administer the medicines/ORS. In total, 35% (16/46) did all three of these tasks.

Eighty percent (37/46) of health workers explained when to return for follow-up, 59% (27/46) told caregivers that the child should be given more liquids, and 78% (36/46) told caregivers to continue to feed and/or breastfeed at home. Education of caregivers on the signs that mean the child needs to be brought back to the health facility were being done as noted below:

Education of Caregivers on the Signs Showing Need to Return Child to Health Facility	Frequency (N = 46)	Percent
Child is not able to drink or is drinking poorly	31	67%
Child develops fever	30	65%
Change in consciousness/lethargic	28	61%
Child is not able to breastfeed or eat	25	54%
Child becomes sicker	25	54%
Child develops fast/difficult breathing	19	41%
Child develops blood in the stool	12	26%

In sum, 91% (42/46) of health workers mentioned three or more of these signs to the caregivers. In addition, 78% (36/46) of health workers took the opportunity to educate caregivers on nutrition.

The average length of the examinations was eleven minutes within a range of one to 21 minutes.

### C. EXIT INTERVIEW – THE SICK CHILD

The caregivers of the same 46 children were interviewed individually shortly after the examinations to assess whether they understood how to give the medicines, and their knowledge of homecare, danger signs, and immunizations as well as care seeking and family planning practices.

Each of the caregivers was asked how many days had passed between the time they first recognized that the child was sick and the day the child was brought to the health facility:



<b>Number of Days Between the Recognition of Symptoms and Care Seeking</b>	<b>Frequency (N = 46)</b>	<b>Percent</b>
0	17	37%
1	9	20%
2	6	13%
3	10	22%
4	2	4%
5	2	4%
<b>Total</b>	<b>46</b>	<b>100%</b>

Each of the caregivers was asked whether their child had received or been prescribed any oral medications during the examination and 76% (34/45) reported they had. The caregivers were asked a series of questions designed to assess whether they knew the correct amount of medicine to give, the frequency of the dose, and the number of days the child needed to receive the medicine. In sum, caregivers knew the correct dosage for 60% (30/50) of the medicines they received. Or, 67% (24/36) of caregivers knew how to correctly give all of the essential medicines they were provided or prescribed.

<b>Caregiver Knowledge of Correct Dosage and Timing per Type of Medicine Prescribed/Provided</b>	<b>Frequency</b>	<b>Percent</b>
Chloroquine tablets/syrup	0/0	0%
Antibiotic tablets/syrup	23/26	88%
Aspirin tablets/syrup or paracetamol	4/17	24%
ORS	3/7	43%

Of the 80% (37/46) of caregivers who said they had received medication(s) during their most recent visit, 89% (33/37) said they were able to get the medicines – 94% (31/33) at the same health facility and 12% (4/33) at a private pharmacy.

When asked what they would do for their child after returning home, the caregivers responded with the following:

<b>Caregiver Knowledge About Aspects of Homecare</b>	<b>Frequency (N = 45)</b>	<b>Percent</b>
Continue feeding or breastfeeding the child	39	87%
Give the same quantity/more fluids to the child	29	64%
Bring the child back if s/he doesn't get better or gets worse	24	53%
Complete the course of medicines/ORS/RHF	14	31%
Does not know	0	0%

In total, 87% (39/45) of caregivers knew at least two aspects of home case-management and 96% (43/45) of caregivers knew at least two signs of the child getting worse as noted below:

<b>Caregiver Knowledge of Warning Signs Showing the Child needs to Return to the Health Facility</b>	<b>Frequency (N = 46)</b>	<b>Percent</b>
Fever begins and does not go away	40	87%
Child has difficulty breathing	22	48%
Vomiting begins or continues	20	43%
Diarrhea continues	18	39%
Child is unable to eat	17	37%
Child has chest indrawing	14	30%
Child is unable to drink	10	22%
Blood in the child's stool	4	9%
Child has convulsions	3	7%
Other	2	4%
Does not know	1	2%

Caregiver knowledge about the benefits of vaccines for mothers and children, specifically what diseases can be prevented by vaccines, was mixed as can be seen in the following table:

<b>Caregiver Knowledge of the Diseases Prevented by Vaccines</b>	<b>Frequency (N = 45)</b>	<b>Percent</b>
Measles	39	87%
Whooping cough	35	78%
Tuberculosis	34	76%
Tetanus	34	76%
Diphtheria	29	64%
Polio	26	58%
Does not know	1	2%

Eighty-two percent (37/45) of caregivers knew the correct number of vaccination visits required for an infant during the first year of life. When asked, all of the caregivers (100% or 46/46) said they knew about side effects associated with immunizations, including the following:

<b>Caregiver Knowledge of Immunization Side Effects</b>	<b>Frequency (N = 44)</b>	<b>Percent</b>
Fever	41	93%
Irritability/crying	37	84%
Swelling	21	48%
Pain at the injection site	16	36%

Fifty-nine percent (27/46) of caregivers reported having received counseling on family planning by the health worker. At the time of the survey, 87% (40/46) of the caregivers were not pregnant. Of them, 63% (25/40) said they did not want to have another child in the next two years or were not sure. Of these caregivers, 4% (1/25) was not using any family planning method and 60% (15/25) were using a modern method as noted below:

<b>Use of Family Planning Methods</b>	<b>Frequency (N = 25)</b>	<b>Percent</b>
<b>Modern Methods</b>		
Injections	9	36%
Pills	4	16%
IUD	2	8%
<b>Other Methods</b>		
LAM	10	40%
Rhythm	4	16%
<b>Not Using Any Family Planning Method</b>		
No FP method used	1	4%

#### **D. HEALTH WORKER INTERVIEW**

The leading health professional with responsibility for child health was interviewed at each of the four health facilities in the area on December 6 and 8, 2003. This included four physicians. The interviews covered supply sourcing, work related challenges, supervision, staff training, EPI-related knowledge, EPI/ANC services, referral and communication with caregivers.

The health facilities are receiving their main medicines and supplies from government (75% or 3/4) and NGO (25% or 1/4) sources. Three of the four health workers (75% or 3/4) said that delays were most commonly due to administrative difficulties and one each said that delays were most commonly due to financial problems or stockouts at the central store.

Health workers reported that they face the following challenges in their jobs:

<b>Primary Challenges Faced by Health Workers</b>	<b>Frequency (N = 4)</b>	<b>Percent</b>
Lack of supplies/stock	3	75%
Poor working environment	3	75%
Inadequate transport	1	25%
Lack of training	1	25%
Low salary	1	25%

All of the health workers (100% or 4/4) reported receiving regular supervision (averaging ten times per month), discussing the above problems with their supervisors, and receiving feedback during their supervision. The majority (75% or 3/4) received this feedback in written reports, and half in the supervisory registers. The health workers reported that the following activities are regularly covered during supervision:

<b>Activities Covered During Supervisory Visits</b>	<b>Frequency (N = 4)</b>	<b>Percent</b>
Observed management of the sick child	3	75%
Discussed problems with supplies and equipment	2	50%
Reviewed reports prepared by health worker	2	50%
Observation of immunization technique	1	25%
Delivered supplies	1	25%
Discussed outreach activities	1	25%
Updated health worker on current information	0	0%

Three of the four (75% or 3/4) health workers interviewed had received training within the past twelve months on child health related topics that included clinical practice. The training topics included pneumonia case management, control of diarrheal disease, nutrition, and clean deliveries.

All of the health workers (100% or 4/4) knew the correct immunization schedule for infants. In addition, all of the health workers knew that women of reproductive age should receive TT and one out of four knew that pregnant women should receive TT. The health workers said that TT was provided on the following occasions:

<b>Occasions TT is Provided as Reported by Health Workers</b>	<b>Frequency (N = 4)</b>	<b>Percent</b>
During curative health care visits made by mothers	4	100%
During visits with child for immunizations or treatment	3	75%
During ANC visits	1	25%

Each of the health facilities provides immunization and antenatal care six days a week.

Three of the four health workers interviewed said that they had experienced the need to refer a child to the next level of care but were unable to do so. Following are the reasons mentioned:

<b>Reasons Why a Child Could not be Referred to the Next Level of Health Care</b>	<b>Frequency (N = 4)</b>	<b>Percent</b>
Parents did not have enough money	3	75%
No transportation was available	2	50%
Next level of health facility was too far	2	50%
Mother refused to go	1	25%
Lack of fuel	0	0%

All of the health workers interviewed (100% or 4/4) knew at least three signs in a sick child that would require referral to the next level health facility. Knowledge of each sign is noted below:

<b>Signs Requiring Referral of the Sick Child</b>	<b>Frequency (N = 4)</b>	<b>Percent</b>
Child is lethargic, abnormally sleepy or unconscious	4	100%
Child has severe pneumonia	3	75%
Child has severe malnutrition or anemia	3	75%
Child has not responded to the usual treatment	3	75%
Child looks very unwell	3	75%
Child has severe dehydration	3	75%
Child has had convulsions	2	50%
Child is not eating or drinking	2	50%
Child vomits everything	2	50%
Child has a high fever	1	25%
Paralysis	1	25%

Each of the health workers were asked what they think their roles are for communicating with caregivers:

<b>Self-Perceived Health Worker Roles in Communicating with Caregivers</b>	<b>Frequency (N = 4)</b>	<b>Percent</b>
Giving information on the danger signs to watch for	3	75%
Ensuring mothers know what to do at home	3	75%
Giving information on what to do at home	2	50%
Giving information on how to give medicine at home	2	50%
Telling caretakers when to come back to the health facility	2	50%
Giving information on how to prevent illness	1	25%
Finding out what caretakers have done at home and what are the symptoms of the child's illness	0	0%
Giving group talks	0	0%

When asked about barriers to communicating with caregivers, health workers responded:

<b>Barriers to Communicating with Caregivers about their Children</b>	<b>Frequency (N = 4)</b>	<b>Percent</b>
They do not listen	2	50%
Not enough time	1	25%
Lack of education materials	1	25%
They do not understand what we say	0	0%
Someone else does it	0	0%
Language barriers	0	0%
It is not important	0	0%
Too crowded	0	0%

## E. EQUIPMENT AND SUPPLIES CHECKLIST

An inventory was done at the four health facilities to quantify staffing levels, physical infrastructure, equipment, supplies, medicines, vaccines, HMIS materials, and patient levels over the previous month.

In the following table, the number of health workers with child case management responsibilities is compared with the number who were present the day of the survey.

Categories of Health Workers at Facilities	Number Assigned to the Facilities	Number Present the Day of the Survey
Physician/Doctors	8	6
Nurses	4	1
Midwives	3	0
Health Assistants	1	0
Community Health Workers	136	69
Pharmacists	2	0
Vaccinators	9	9
CHS	4	7
FHS	4	7
MCH	3	5
MT	3	3

Three of the four health facilities (75% or 3/4) reported having at least one female health worker on staff trained in family planning methods.

An inventory of the fourteen health facilities surveyed found the following infrastructure in place:

Health Facility Infrastructure	Frequency (N = 4)	Percent
Adequate seating for patients	3	75%
Covered waiting area	2	50%
Potable water	2	50%
Functional toilet or latrine	4	100%
Functional waste disposal area/pit	4	100%
Health education posters in the local languages on display	0	0%
ORT corner present and in use	2	50%

All four of the health facilities have a functioning bicycle and one has a working motorcycle. None, however, have a functioning vehicle. One of the health facilities (25% or 1/4) has a functioning megaphone and all (100% or 4/4) of the health facilities have flip charts and posters used for social mobilization. The following table lists the functioning medical equipment available at the health facilities:

<b>Working Medical Equipment Available at Health Facilities</b>	<b>Frequency (N = 4)</b>	<b>Percent</b>
Adult weighing scale	4	100%
Baby weighing scale	3	75%
Salter	4	100%
Thermometer	3	75%
Stethoscope – Regular	4	100%
Stethoscope – Obstetrical	4	100%
Otoscope	3	75%
Tongue Depressor	3	75%
Watch/timing device	1	25%
Steam sterilizer	2	50%
Cooker or stove	4	100%
Measuring and mixing utensils	2	50%
Cups and spoons	2	50%

Specific to EPI equipment, each of the four facilities has a kerosene refrigerator in varying condition. Two were in good shape, one was fair, and one was poor. Three of the four had a freeze-watch indicator and a thermometer inside. Three fourths of the health facilities had temperature charts and each of these was up to date. None had any recording of a temperature outside the safe range. Each of the four health facilities had cold packs and cold boxes, which were all in good condition. All four health facilities reported having all four childhood vaccines (BCG, OPV, DPT and measles) and TT in stock. None of these vaccines were frozen.

A visual review of drugs and other supplies found the following present:

<b>Availability of Drugs and Other Supplies at Health Facilities</b>	<b>Frequency (N = 4)</b>	<b>Percent</b>
Penicillin tablets/syrup	0	0%
Ampicillin tablets/syrup	1	25%
Cotrimoxazole	2	50%
Nalidixic acid	0	0%
Chloroquine tablets	2	50%
Injectable quinine	0	0%
Injectable penicillin	2	50%
Injectable chloramphenicol	1	25%
Paracetamol	0	0%
Aspirin	4	100%
Tetracycline eye ointment	1	25%
Gentian violet	3	75%
Iron	4	100%
Vitamin A	4	100%
Mebendazole/piperazine	4	100%
Sterile water/injection	3	75%

ORS	4	100%
IV solution	1	25%
Needles	2	50%
Syringes	2	50%
Condoms	1	25%
Birth control pills	4	100%
Injectable birth control	4	100%

Half of the health facilities had expired medicines in stock, including adrenaline injectable and algfen tablets. Each of the four health facilities had experienced stock outs within the 30 days prior to the survey, including syringes, essential medicines, and family planning supplies. Half (50% or 2/4) of the facilities had their drugs and other supplies adequately organized and appropriately stored.

Health facilities had the following documentation and record keeping forms available on the day of the survey:

<b>Documentation and Record Keeping</b>	<b>Frequency (N = 4)</b>	<b>Percent</b>
Immunization registry <sup>14</sup>	4	100%
Immunization tally sheet	3	75%
Stock of vaccination/child health cards	4	100%
Stock of TT/maternal health cards	4	100%
Stock of essential drugs cards	3	75%
Notifiable disease report forms	2	50%
All essential monthly reporting forms <sup>15</sup>	3	75%
A patient register <sup>16</sup>	4	100%

Based on a review of the health facility registries, the survey found the following:

<b>Average Patient Load Per Facility Type</b>	<b>BHC (3)</b>	<b>MCH (1)</b>
Average Number of patients seen in the previous month	117	344
Average Number of patients 0-4 seen in the previous month	27	134
Average number of patients seen per day per facility	7	28

<sup>14</sup> All four of the immunization registries were up to date.

<sup>15</sup> All three of the health facilities that had essential monthly reporting forms were up to date.

<sup>16</sup> All four of the health facilities' patient registries were up to date.



## II. SUMMARY CONCLUSIONS AND RECOMMENDATIONS:

This section compares key results from the original baseline survey done in 1999 with the results from the December 2003 survey and provides comments and recommendations from SC staff and the MOH from their meeting on January 26, 2004.

***Assessment, Diagnosis, and Treatment of the Sick Child by Health Workers:*** Significant improvement was found in the initial assessment done of sick children at health facilities. None of the children had all four assessment tasks completed in 1999 (asking the child's age, weighing the child, plotting child's weight on a growth chart, and checking the child's temperature). This increased to 41% (19/46) in 2003. The MOH credited improved monitoring and regular feedback after monitoring visits as factors contributing to this improvement. The Government is currently field-testing guidelines, which once finalized and put into practice, should help to improve the initial assessments as well as health care overall for children at MOH facilities. Two other factors might be having an impact on these rates: one of the four health facilities surveyed did not have a functioning thermometer to record the child's temperature and plotting the child's weight on growth monitoring cards is not the responsibility of the medical officers, so this might have been underreported.

The initial assessment of immunization status of both children and women improved significantly, with all of the health workers checking all of the children's cards and 84% (36/43) of the female caregivers' cards being checked. This represents a significant increase from 6% in 1999 to 48% in 2003. The MOH and SC/US credited the annual EPI refresher courses for this success.

The number of assessment tasks completed by health workers specific to diarrhea, fever, and ARI remained relatively low. For instance, while the number of health workers who completed all of the ARI-related tasks doubled from the 1999 rate of 20%, it was still only 41%. MOH and US/SC said that the primary reason more health workers were not completing all four ARI tasks was due to the lack of consistent feedback or refresher training since 2001, especially for medical officers. In addition, only one of the four health facilities surveyed had a working timer for counting breaths, which would have further limited these assessments. By contrast, assessment of nutritional status showed positive improvement on all three related assessment tasks:

<b>Nutrition Assessment Tasks Completed</b>	<b>1999</b>	<b>2003</b>
Both Feet Checked for Edema	23%	76% (35/46)
Undressed and checked for wasting	31%	65% (30/46)
Checked for palmer or conjunctive pallor	29%	59% (27/46)

MOH and SC stated that the continuous training on nutritional assessment, provided through Save the Children's Food Distribution and Nutritional Surveillance Program, was a major factor here.

The survey validators agreed with the medical officers in just over two-thirds of their diagnosis

in the 2003 survey.<sup>17</sup> While the rates of agreement were highest on diarrheal diseases, dysentery, and pneumonia, the rates for more common, less severe respiratory and ear infections were not as strong, with both colds and acute ear infections being miss-diagnosed about half of the time. Agreement between the survey validators and the health workers on the medications prescribed and the treatment provided shows that room remains for improvement, especially with regard to pneumonia case management.

R1. To help maintain the improvements to date in the immunization assessments, the medical officers' role could be expanded from not only requesting cards and checking them, but also actively giving advice on referral and potential side effects. This would require only slight changes to the training curriculum and supervisory checklists, but could help to further improve coverage.

R2. The project should further explore reasons why the ARI, fever, and diarrhea associated assessment tasks are not being done consistently, whether changes need to be made in the training/supervision, equipment needs to be acquired/repared, etc. This could be done through interviews or mini focus group discussions with health facility personnel.

R3. Objective 31 requires the development of a quality index score for the EPI intervention. However, the health worker and caregiver knowledge of the EPI schedule, health worker review of cards, and the cold chain infrastructure were all very strong. If the 2002 KPC EPI data, particularly for completed immunizations, was also high, then this objective could be cut or changed to a 'maintenance' objective that would measure the sustainability of the EPI intervention after the conclusion of Save the Children's direct involvement in the area.

R4. Further training and refresher training of medical officers on the use of the Sick Child Management and Treatment Checklist could help to improve the consistency, accuracy, and overall quality of the initial assessments at the health facilities.

***Educating Caregivers on Health:*** The survey, along with anecdotal reports, found improvements in health worker counseling of caregivers from 1999 to 2003. This was attributed to the trainings and refresher trainings on communication skills and caretaker counseling, which were initiated by the project in 2000.

#	Counseling of Caregivers by Health Workers	1999	2003
1	Explained how to administer medicines/ORS.	86%	85% (39/46)
2	Demonstrated how to administer medicines/ORS.	29%	54% (25/46)
3	Verified caregiver understanding medicine/ORS administration through open questions.	6%	52% (24/56)
	Percent of health workers who did tasks 1-3 above.	6%	35% (16/46)

<sup>17</sup> Validators were not available to review and assess the accuracy of the diagnosis done in 1999, therefore, comparison over time cannot be provided here.

	Explained when to return for follow-up.	75%	80% (37/46)
	Told caregivers the child should be given more liquids at home.	32%	59% (27/46)
	Told caregivers to continue to feed and/or breastfeed at home.	60%	78% (36/46)

R5. Including these counseling topics within the MOH's Sick Child Assessment and Management Checklist and discussing them during regular supervision should be considered to help ensure that these messages are provided consistently.

**Family Planning:** In addition to child health, the project added a brief family planning component to the 2003 version of the IHFA survey questionnaire. Just over half of the adult caregivers received counseling on family planning from the health worker and the use of modern family planning methods is very limited. Family planning is still considered 'low profile' due to the lack of MOH staff training on family planning, educational materials, and family planning content incorporated into community based health education messages. Of promise, family planning supplies are now being provided through UNICEF.

R6. The project needs to identify all culturally appropriate strategies for communicating its family planning messages. It is not possible to determine from the IHFA data whether the low rates of modern family planning method usage are the result of insufficient supply, lack of knowledge on their availability/efficacy, or a lack of interest due to cultural, religious, or other factors. An understanding of these issues is critical to the success of the project's child spacing intervention. While some answers might come from the KPC survey results for the area, focus group discussions held separately with males and females would provide important input to the design of the project's health education messages and dissemination strategies.

**Care Seeking Behavior:** Caregivers are taking sick children to health facilities sooner than in 1999, with nearly twice as many seeking care the same day symptoms become apparent and fewer are waiting three or more days to seek care. These positive changes were the result of health education provided by female staff in the clinics, health education provided by both female and male outreach workers in the field, and the project's ARI and CDD campaigns.

R7. While timing of care seeking has improved markedly over the previous four years, interviews with caregivers who are delaying care might help to identify unrecognized barriers which the project could potentially help to address. Possible interview questions could include: How did you first recognize the symptoms of the illness? When did you first decide to seek help? Who did you go to seek help? What would have helped you to come to the health care facility earlier?

**Home Care:** Twice as many caregivers now know how to administer the essential medicines, increasing from 32% in 1999 to 67% (24/36) in 2003. However, knowledge of the preparation of ORS has declined by a third during the same period. Caregiver knowledge of the common aspects of homecare has improved or remained high in continued feeding/breastfeeding and

giving fluids. Overall, 96% (44/46) of caregivers knew at least two or more signs showing that the child needs to return to the health facility, which was a significant improvement over the 1999 rate of 68%. Some topics that require further promotion include knowing to bring the sick child back to the health facility when s/he gets worse and the importance of completing the entire dose of medicines, which decreased significantly from 52% to 31% (14/45).

R8. Since the 2003 baseline for objective 27, increasing caretaker knowledge of how to administer essential drugs, already exceeds the current target of 60% by seven percentage points, this target either needs to be increased or the objective should be modified or dropped. One option would be to change this objective to ‘knowing how to prepare and administer ORS at home,’ especially since home-based treatment of diarrheal diseases is critical in the area and knowledge of ORS preparation is low.

R9. The 2003 baseline for objective 28 is 27 percentage points above the current target. However, two of the most important aspects of homecare were not well known by caregivers – the need to return a child to a health facility when s/he gets worse and the need to complete the course of medicine. The number of correct responses required to meet the objective could be increased from two to three or four to help ensure that these important messages are being understood.

R10. The target for objective 29 needs to be amended because the current rate is nearly 100% or 36 percentage points higher than the target of 60%. As with objective 28 above, the number of correct answers required to meet the objective could be increased from two to more, especially because of the large number of possible correct answers (nine) and the fact that in only one of these nine possible answers did over half of the caregivers respond.

R11. In their meetings, the MOH and SC/US identified several strategies for improving caretaker knowledge and the efficacy of homecare services:

- Provide facility-based supervision of outreach workers, who are responsible for teaching mothers how to prepare ORS and communicate the project’s health education messages.
- Provide refresher training to MOH facility-based and outreach staff using the new MOH Guidelines.
- Increase the use of the Sick Child Management Checklist during supervision.
- Improve the consistency and timeliness of supervisory feedback to staff.
- Provide further training to health workers on caregiver counseling, focusing most closely on the topics identified above.

***Other Recommendations:***

R12. The leading challenges that health workers report facing are the lack of medicines, the growing number of clients, and the poor working environment. 2003 experienced the worst stockouts in the health facilities, which has been ameliorated somewhat by the supplies provided by UNICEF over the previous four months. The challenge is going to be how to maintain these stocks in the future once supplies end. The MOH noted that the shortage of drugs might be due in part to misuse and over prescription. If this is not the case, then the project needs to revise its existing quota system to ensure that all the essential medicines are available at all times. The

project should also explore the feasibility and appropriateness of revolving drug funds to ensure the continued availability of essential drugs throughout the project area.

R13.<sup>18</sup> The indicators and means of verification for measuring the quality index score for maternal and newborn care need to be developed. (Reference Objective 32.) In a November 6, 2003 email Dr. Winnie Mwebesa suggested, “using the ‘case fatality rate,’ which is the total number of maternal deaths from direct obstetric complications divided by the number of women admitted with these conditions. It is measured in facilities providing comprehensive emergency obstetric care that is the six basic signal functions (parenteral administration of antibiotics, oxytocic drugs and anticonvulsants, manual removal of placenta, removal of retained products, assisted deliveries) plus obstetric surgery and blood transfusion services. The information can be obtained from facility records and the data needed is the number of maternal deaths within the facility and the number of women diagnosed with one or more of the complications at the facility during the time period. A consensus needs to be reached on the definition of each obstetric complication. The CFR should not exceed 1%. Limitations on the indicator can be found in the Compendium of Indicators for Evaluating Reproductive Health Programs: <http://www.cpc.unc.edu/measure/publications/ms-02-06/5bpartd.pdf> page 18.” She also suggested other useful indicators that could be drawn from the Service Provision Assessment tool at: <http://www.cpc.unc.edu/measure/publications/tools/cmnht/t6/indicators.pdf>.

These could include:

- Use of the partogram to monitor labor if they are available. This would look at the quality of care during labor.
- Percent of facilities with protocols or guidelines for managing normal deliveries and common complications.
- Percent of facilities offering 24 hour delivery services
- Percent of facilities that report providing c-sections and have all the essential equipment and have skilled personnel for providing c-s.
- Percent of facilities with basic equipment for emergency care of the newborn available.
- Percent of facilities that have a system for reviewing maternal/newborn deaths and "near miss" deaths.

---

<sup>18</sup> This recommendation is also included in the Jawzjan IHFA Report, as it is relevant to both project sites.

## **ATTACHMENTS**

# 1. OBSERVATION CHECKLIST – SICK CHILD

Province/District: _____	HW Category: _____
Date: _____	Facility Name: _____
Facility Type: _____	Interviewer: _____
Child's age: _____ (months) ID Number: _____	

<b>Begin Timing the Observation Now. Time: _____</b>
--

1. What reason does the caretaker give for bringing the child to the health facility? **(CHECK ALL THAT APPLY.)**
  - Diarrhea/vomiting.....[ ]
  - Fever/malaria.....[ ]
  - Difficulty breathing/cough/pneumonia.....[ ]
2. Does the health worker ask of the age of the child or have the age available? Y N
3. a. Is the child weighed? Y N
  - b. Is the child's weight plotted on a growth chart? Y N
4. Is the child's temperature checked? Y N

Does the Health Worker ASK about (or does the caretaker REPORT) -	Does the Health Worker perform these EXAMINATION TASKS?
<b>Danger signs:</b>	
5. Not able to drink or breastfeed? Y N	13. Look for lethargy or unconsciousness? Y N
6. Vomits everything? Y N	
7. Convulsions? Y N	
8. Change in consciousness/lethargic/Sleepy Y N	
<b>9.a Diarrhea?</b> Y N	14. Observe drinking or breastfeeding? Y N
.b For how long? Y N	15. Pinch the skin on abdomen? Y N
.c Is there blood in the stool? Y N	16. Look for sunken eyes? Y N
10.a Cough or difficult breathing? Y N	17. Raise the shirt? Y N
.b For how long? Y N	18. Count breaths/minute? Y N
	19. Look for chest indrawing? Y N
<b>11.a Fever?</b> Y N	20. Look or feel for stiff neck? Y N
.b For how long? Y N	21. Look for generalized rash? Y N
	22. Look for runny nose/red eyes? Y N
<b>12.a Ear problems?</b> Y N	23. Look for pus from ear? Y N
.b Ear pain? Y N	24. Feel for swelling behind ear? Y N
.c Ear discharge? Y N	
.d IF YES, for how long? Y N	
	<b>Malnutrition:</b>
	25. Undress and look for wasting? Y N
	26. Look for palmar or conjunctival pallor? Y N
	27. Look for edema of both feet Y N

A. All danger signs (Q.5 to Q.8 [or Q.13]) assessed?	Y N
B. All main symptoms (Q.9 to Q. 12) assessed?	Y N
C. Number of diarrhea assessment tasks completed? (Circle one.) (History and Examination)	0 1 2 3 4 5
D. Number of ARI assessment tasks completed? (Circle one.) (History and Examination)	0 1 2 3 4
E. Number of fever assessment tasks completed? (Circle one.) (History and Examination)	0 1 2 3 4
F. Nutritional status correctly assessed?	Y N

#### Immunization and Screening

- 28.a Does the health worker ask for the child's immunization card? Y N  
**IF NO, GO TO QUESTION 29.**
- .b **IF YES**, does the child have a card? Y N
- .c If the child referred for vaccination?  
 \_\_\_ Today \_\_\_ Another day \_\_\_ Not referred \_\_\_ Up to date
- 29.a Does the Health Worker ask for the caretaker's immunization card? N/A Y N  
**IF NO OR N/A, GO TO QUESTION 30.**
- .b **IF YES**, does the caretaker have the card? Y N
- .c Is the mother referred for vaccination? Y N  
 \_\_\_ Today \_\_\_ Another day \_\_\_ Not referred \_\_\_ Up to date

#### Diagnosis:

How does the health worker classify the child?			
30. Simple diarrhea.....[YES] [NO]	39. Very severe febrile disease		Y N
a. No dehydration.....[YES] [NO]	40. Malaria		Y N
b. Some dehydration.....[YES] [NO]	41. Severe complicated measles		Y N
c. Severe dehydration.....[YES] [NO]	42. Complicated measles		Y N
31. Dysentery.....[YES] [NO]	43. Measles		Y N
32. Persistent diarrhea.....[YES] [NO]	44. Fever, other cause		Y N
33. Severe persistent diarrhea.....[YES] [NO]	SPECIFY:		
34. Severe pneumonia.....[YES] [NO]	45. Mastoiditis		Y N
35. Pneumonia.....[YES] [NO]	46. Acute ear infection		Y N
36. Upper respiratory inf. (cough/cold) [YES] [NO]	47. Chronic ear infection		Y N
37. Severe malnutrition..... [YES] [NO]	48. No diagnosis		Y N
38. Moderate malnutrition/anemia [YES] [NO]	49. Other diagnosis: _____		

#### If validation is performed:

Ga. Health worker classification agrees with validator?	Y N
Gb. Severely ill child classified correctly?	Y N

#### Treatment

What does the health worker administer or prescribe for the child?			
50. Immediate referral?	Y N	58. ORS	Y N
51. Antimalarial injection	Y N	59. Antidiarrheal/antimotility	Y N
52. Antimalarial tablets/syrup	Y N	60. Metronidazole tablets/syrup	Y N
53. Paracetamol/aspirin	Y N	61. Tablets/syrup unknown type	Y N
54. Tepid bath	Y N	62. Injection Unknown type	Y N
55. Antibiotic ointment	Y N	63. None	Y N
56. Antibiotic tablets/syrup	Y N	64. Other (Specify: _____)	Y N
57. Vitamin A or vitamins	Y N		



H.	Is the medication appropriate for the diagnosis?	Y	N
----	--	---	---

I.a	Diarrhea case received appropriate medication?	N/A	Y	N
I.b	Pneumonia case received appropriate medication?	N/A	Y	N
I.c	Dysentery case received appropriate medication?	N/A	Y	N

If validation performed:

J.a	Is the child treated correctly?	Y	N	
J.b	Severe classification correctly referred?	N/A	Y	N
J.c	Pneumonia case correctly treated?	N/A	Y	N
J.d	Diarrhea case correctly treated?	N/A	Y	N
J.e	Dysentery case correctly treated?	N/A	Y	N

Interpersonal communication:

For all oral medication:

65 a. Does the health worker explain how to administer medications/ORS? Y N  
 b. Does the health worker demonstrate? N/A Y N  
 c. Does the health worker ask open-ended questions to verify the comprehension of how to administer medications/ORS? Y N

K.	Number of treatment tasks performed?:	(0 to 3)
----	---------------------------------------	----------

66. Does the health worker explain when to return for follow-up? Y N  
 67. Does the health worker explain the need to give the more liquid at home? Y N  
 68. Does the health worker explain the need to continue feeding or breast-feeding at home? Y N  
 69. Does the health worker tell the caretaker to bring the child back for the following signs?  
 - Child is not able to drink or drinking poorly Y N  
 - Child is not able to breast-feed/eat Y N  
 - Child becomes sicker Y N  
 - Child develops a fever Y N  
 - Child develops fast or difficult breathing Y N  
 - Child develops blood in the stool Y N  
 - Change in consciousness/lethargic Y N

L.	Are at least 3 of the Q.68 messages circled?	Y	N
----	--	---	---

70. Does the health worker give the caretaker any advice on nutrition? Y N

Check the time of the observation as the caretaker leaves: Time: _____
Duration of observation: _____ (minutes)

### END OF HEALTH WORKER OBSERVATION

- The surveyor may need to ask the health worker about the diagnosis made and the treatment given during the consultation, but only if these two components were not stated during the consultation.
- The surveyor *must complete* this form *before* the next child observation.

## 2. EXIT INTERVIEW - SICK CHILD

Province/District: _____	Date: _____
Facility Name: _____	Facility Type: _____
Interviewer: _____	Child's age: _____ (Months)
Child ID number: _____	

**Greet the caretaker and say that you would like to ask some questions about his/her visit to the health facility.**

1. Did the health worker give you or prescribe you any oral medicines at the health facility today?      Y N

**If NO, go to question 2**

**IF YES,** compare the caretaker's medications with samples for identification of the oral medication.

Complete the table below for the listed oral medications. Fill in the table below by asking:  
**HOW MUCH** medicine will you give the child **EACH TIME**?  
**HOW MANY TIMES** will you give it to the child **EACH DAY**?  
**HOW MANY DAYS** will you give the medicine to the child?

If the caretaker's answer is:

"As required," write AR in the appropriate cell.

"Until completed," writej UC in the appropriate cell.

"I don't know," write DK in the appropriate cell.

Medicine	How much each time?	How many times/day?	How many days?	All correct Yes/No
Chloroquine tablets/syrup				
Antibiotic Tabs/syp Name: _____ Dose/tablets: _____				
Aspirin tabs/syp Or paracetamol Dose/tablets: _____				
ORS				
Other: _____ Dose/tab: _____				

**A. Caretaker knows how to give ALL essential medications correctly?      N/A**  
**Y N**

2. What will you do for your child when you return home? **(CHECK ALL RESPONSES.)**

- Does not know.....[    ]
- Continue feeding or breastfeeding the child.....[    ]
- Give same quantity/more fluids to the child.....[    ]
- Complete course of medications/ORS/RHF.....[    ]
- Bring the child back if he/she doesn't  
get better or gets worse.....[    ]
- Other: Specify: \_\_\_\_\_[    ]

**B. Caretaker knows at least 2 aspects of home case-management?      Y N**

3. How will you know if the child becomes worse at home and needs to return to a health facility? **(CHECK ALL RESPONSES.)**

- Doesn't know ..... [ ]
- Fever begins or doesn't go away .. [ ]
- Child unable to eat ..... [ ]
- Diarrhea continues ..... [ ]
- Child has chest indrawing ..... [ ]
- Vomiting begins or continues ..... [ ]
- Child unable to drink ..... [ ]
- Child has convulsions ..... [ ]
- Child has difficulty breathing ... [ ]
- Blood in stool..... [ ]
- Other: Specify \_\_\_\_\_ [ ]

**C. Caretaker knows at least 2 signs of child getting worse at home? [YES]  
[NO]**

4. Which diseases will be prevented by the immunizations you or your child has received? **(CHECK ALL RESPONSES.)**

- Don't know [ ]
- Diphtheria [ ]
- Tetanus [ ]
- Whooping cough [ ]
- Measles [ ]
- Tuberculosis [ ]
- Polio [ ]
- Other [ ] Specify \_\_\_\_\_

5.a Do you know what might happen as a side effect after the immunization? Y N  
**IF No, jump to Q 6**

B.If YES, what were you told? **(CHECK ALL RESPONSES.)**

- Fever .....[ ]
- Irritability/Crying.....[ ]
- Pain at injection site.....[ ]
- Swelling.....[ ]
- Other.....[ ] Specify \_\_\_\_\_

6. How many vaccination visits does a child need in the first year of life to complete the series of vaccinations? \_\_\_\_\_ (1=Correct, 2=Incorrect, 9=Doesn't know)

7.a Did your child receive an immunization today? Y N

.b **IF NO**, Was your child referred for vaccination another day? (Prompted question.  
**CHECK SINGLE RESPONSE.)**

- Referred for vaccination another day.....[ ]
- Not referred for vaccination.....[ ]
- Up to date.....[ ]

8. Do you have your child's vaccination card?

- YES.....[ ]
- NO.....[ ]
- LOST.....[ ]
- NEVER RECEIVED.....[ ]
- LEFT AT HOME.....[ ]

If the caretaker has the card, record the dates of ALL VACCINES GIVEN, both today and in the past, and the child's birth date and age

Birth date: \_\_\_\_\_

Age: \_\_\_\_\_ Months

Immunization	Received
Polio-0 (birth)	Y N
BCG	Y N
DPT1	Y N
Polio1	Y N
DPT2	Y N
Polio2	Y N
DPT3	Y N
Polio3	Y N
Measles	Y N

**D. Child is up to date?**

**Y N**

9. Do you have your own vaccination card?

YES.....[ ]  
 NO.....[ ]  
 LOST.....[ ]  
 NEVER RECEIVED.....[ ]  
 LEFT AT HOME.....[ ]  
 N/A.....[ ]

IF YES, copy the caretaker's tetanus toxoid vaccinations in the table below. If the caretaker's TT doses are recorded on the child's vaccination card, copy them here also.

IMMUNIZATION	RECEIVED
TT-1	Y N
TT-2	Y N
TT-3	Y N
TT-4	Y N
TT-5	Y N

**E. Caretaker has received at least TT-2?**

**Y N**

10.a Did you receive tetanus toxoid vaccination today? Y N

.b IF NO, Were you referred for vaccination? (CHECK SINGLE RESPONSE)

Referred for vaccination another day.....[ ]  
 Not referred for vaccination.....[ ]  
 Up to date.....[ ]

11.a Were you prescribed any oral medication at your last visit? Y N

.b IF YES, were you able to get your medicine? Y N

.c IF YES, where did you get your medicine?

This health facility.....[ ]  
 Private pharmacy.....[ ]

Another health facility/hospital.....[    ]  
Drug vendor.....[    ]  
Other.....[    ]Specify:\_\_\_\_\_

.d **IF NO**, why could you not get the medication?

No drugs available.....[    ]  
No money/could not afford.....[    ]  
Other.....[    ] Specify:\_\_\_\_\_

12. Did the Health Worker talk to you about family planning?        Y N

13. Are you currently pregnant?        Y N  
    **IF YES**, end the interview.

14. Do you want to have another child in the next two years?

\_\_\_\_ Yes  
\_\_\_\_ No  
\_\_\_\_ Not sure

**IF YES**, end the interview.

15. Are you currently doing something or using any method to delay or avoid getting pregnant?        **IF YES**, what are you doing? (CHECK ALL THAT APPLY.)

____ Norplant	____ Injections	____ Pills	____ IUD
____ Diaphragm	____ Condom	____ Foam Gel	____ T. Ligation
____ Vasectomy	____ Rhythm	____ Abstinence	____ Withdrawal
____ Lactational Amenorrhoea			
____ Other: Specify _____			

**16. How long was it before your child got sick and your visit BHU today?:\_\_\_\_\_ (000=Today, 999=Don't know) ####**

**END OF INTERVIEW**

Thank the caregiver for answering your questions and ask if he/she has any questions. Be sure that the caretaker knows how to prepare ORS for a child with diarrhea, when to return for vaccination, how to give the prescribed medications, and when to return if the child becomes worse at home.
---

### 3. HEALTHWORKER INTERVIEW

Province/District: \_\_\_\_\_ Health Worker Category: \_\_\_\_\_  
 Date: \_\_\_\_\_ Facility name: \_\_\_\_\_  
 Facility Type: \_\_\_\_\_ Interviewer's name: \_\_\_\_\_

**Introduce yourself to the health worker. Tell him/her that you would like to ask some general questions about the health facility, followed by questions about his/her job.**

1. Where does the health facility usually gets its main medications and supplies? **(CHECK A SINGLE RESPONSE.)**
  - ☐ Government Supplier ☐ NGO Mission
  - ☐ Community Pharmacy ☐ Other SPECIFY: \_\_\_\_\_
  - ☐ Private pharmacy supplier
2. How are supplies usually received? **(CHECK A SINGLE RESPONSE.)**
  - ☐ Delivered to facility ☐ Both
  - ☐ Picked up from the supplier ☐ Other SPECIFY: \_\_\_\_\_
3. What is the most common cause of a delay in delivery of supplies? **(CHECK A SINGLE RESPONSE.)**
  - ☐ Inadequate transport ☐ Insufficient staff
  - ☐ Administrative difficulties ☐ Rupture of stock at central store
  - ☐ Financial problems ☐ Other SPECIFY: \_\_\_\_\_
  - ☐ Insufficient fuel
4. Are you regularly supervised? Y N  
 If NO, go to question 9.
5. Do you have a schedule for supervisory visits? Y N
6. How many times have you had a visit from a supervisor:
  - In the last six months : \_\_\_\_\_ (number of times)
  - In the last 12 months : \_\_\_\_\_ (number of times)
  - Supervisor works here and sees worker daily [ ]
7. What did your supervisor do last time he/she supervised you? **(CHECK ALL THAT APPLY)**
  - ☐ Delivered supplies (fuel, medicines, etc)
  - ☐ Observed immunization technique
  - ☐ Observed management of sick children
  - ☐ Reviewed reports prepared by health worker
  - ☐ Updated health worker on current information
  - ☐ Discussed problems with supplies and equipment
  - ☐ Other: SPECIFY: \_\_\_\_\_
- 8.a Did you receive feedback from that supervisory session? Y N
  - b IF YES, in what form?
    - ☐ Supervisory register ☐ Written Report
    - ☐ Oral report ☐ Other SPECIFY: \_\_\_\_\_

9. What are the most difficult problems that you face in doing your job?  
(CHECK ALL THAT APPLY.)

- ☐ Lack of training
- ☐ Caretakers don't bring children to clinic
- ☐ Lack of time
- ☐ Staff shortages
- ☐ Lack of supplies and/or stock
- ☐ Lack of supervision
- ☐ Lack of feedback on performance
- ☐ Inadequate transport
- ☐ Lack of motivation
- ☐ Poor working environment
- Other ☐ Specify \_\_\_\_\_

10. Have you discussed these problems with your supervisor? Y N

11. How many child-health-related training sessions have you received in the last 12 months? \_\_\_\_\_

**If NO training received, go to Question 14.**

12. What type of training was it? \_\_\_\_\_

13. Did your last training involve any clinical practice? Y N

14. In this health facility at what ages do you give:

(AGES IN WEEKS EXCEPT FOR MEASLES WHICH SHOULD BE IN MONTHS.)

Vaccines	First	Second	Third	Fourth
DPT				
Polio				
BCG				
Measles				

<b>A. EPI vaccination schedule all correct?</b>	<b>Y N</b>
---	------------

15. To whom do you give tetanus toxoid? (CHECK ALL THAT APPLY.)

- ☐ Does not know
- ☐ Pregnant women
- ☐ Women of childbearing age (15-49)

16. On what occasion would you give tetanus toxoid? (CHECK ALL THAT APPLY.)

- ☐ Antenatal clinic visit
- ☐ Visit for curative services of mother
- ☐ Visit with child for immunization or treatment

17. On what days are immunizations given? (CIRCLE DAYS.)

SA SU M T W TH F      Number of immunization days/week: \_\_\_\_\_

18.a Does the health facility have an antenatal clinic? Y N

.b IF YES, on what days is the clinic held? (CIRCLE DAYS.)

SA SU M T W TH F      Number of immunization days/week: \_\_\_\_\_

.c If NO, why are antenatal clinics not held? (CHECK ALL THAT APPLY)

- ☐ Doesn't know
- ☐ No staff
- ☐ No supplies
- ☐ No training
- ☐ No space available
- ☐ Other: Specify \_\_\_\_\_

19. What are the signs that would make you refer a child to the next level of health facility? **(CHECK ALL THAT APPLY.)**

- ☐ Child is lethargic/abnormally sleepy/unconscious
- ☐ Child has not responded to usual treatment
- ☐ Child looks very unwell
- ☐ Child is not eating or drinking
- ☐ Child has severe dehydration
- ☐ Child has severe malnutrition/anemia
- ☐ Child has had convulsions
- ☐ Child has a very high fever
- ☐ Child vomits everything
- ☐ Child has severe pneumonia
- ☐ Other: Specify \_\_\_\_\_

<b>B. Health worker knows at least 3 signs for referral?</b>	<b>Y N</b>
--	------------

20.a Have you ever wanted to refer a child to the next level of health facility but have not been able to do so? Y N

**IF NO**, go to question 21

.b **If YES**, why could you not refer the child? **(CHECK ALL THAT APPLY.)**

- ☐ Next level HF too far
- ☐ No transport available
- ☐ Parents didn't have enough money
- ☐ Mother refuse to go
- ☐ No fuel available
- ☐ Other: Specify: \_\_\_\_\_

21. What do you see as your role in communicating with caretakers when they bring their child to the health facility? **(CHECK ALL THAT APPLY.)**

- ☐ Giving information on danger signs to watch for
- ☐ Giving information on what to do at home
- ☐ Giving information on how to give medicine at home
- ☐ Finding out what caretakers have done at home and what are the symptoms of the child's illness
- ☐ Giving information on how to prevent illness.
- ☐ Telling caretakers when to come back to the H.F.
- ☐ Ensuring that mothers understand what to do at home.
- ☐ Giving group talks.
- ☐ Other: Specify \_\_\_\_\_

22. What prevents you from communicating with caretakers when they bring their child to the health facility? **(CHECK ALL THAT APPLY.)**

- ☐ I don't know how
- ☐ Someone else does it
- ☐ They do not listen
- ☐ Language barriers prevent effective comm.
- ☐ I don't have any education materials
- ☐ It is not important
- ☐ It isn't really my role
- ☐ No time
- ☐ They don't understand what we say
- ☐ Other [ ] Specify \_\_\_\_\_

**END OF THE HEALTH WORKER INTERVIEW**

<b>Thank the Health Worker for his/her cooperation and answer any questions that he/she may have about the correct recommendations for immunizations or management of sick children.</b>
--



#### 4. EQUIPMENT AND SUPPLIES CHECKLIST (Andkhoy)

Province/District: _____	Date: _____
Facility Name: _____	Facility Type: _____
Interviewers: _____	

Category of health staff **with child case management responsibilities**  
(curative and preventive)

Category	Number assigned to the facility	Number present the day of the survey
Physician/doctor		
Nurse		
Midwife		
Health Assistant		
Community Health Worker		
Pharmacist		
Vaccinators		
Others: Specify		

1. Have any of the female health workers at your facility been trained in family planning methods? ..... [YES] [NO]

##### **Patient and Worker Accommodation**

2. Is there adequate seating for patients? ..... [YES] [NO]
3. Is there a covered waiting area? ..... [YES] [NO]
4. Is there potable water? ..... [YES] [NO]
5. Is there a functional toilet or latrine? ..... [YES] [NO]
6. Is there a functional waste disposal area/pit? . [YES] [NO]
7. a Are health information posters displayed? ..... [YES] [NO]
- b **IF YES**, Are they written in the local language? [YES] [NO]
8. Is an ORT corner present and being used? ..... [YES] [NO]

##### **Equipment and supplies**

**Are the following equipment and supplies present in the clinic?**

9. Transportation [YES] [NO] **IF YES, in working order?** [YES] [NO]
  - Vehicle [YES] [NO] **IF YES, in working order?** [YES] [NO]
  - Motorcycle [YES] [NO] **IF YES, in working order?** [YES] [NO]
  - Bicycle [YES] [NO] **IF YES, in working order?** [YES] [NO]
10. Social Mob. Equipment:
  - Megaphone [YES] [NO] **IF YES, in working order?** [YES] [NO]
  - Flip-chart [YES] [NO] **IF YES, in working order?** [YES] [NO]
  - Posters [YES] [NO] **IF YES, in working order?** [YES] [NO]
11. Weighing Equipment
  - Adult weight scale [YES] [NO] **IF YES, in working order?** Y/N
  - Baby weight scale [YES] [NO] **IF YES, in working order?** Y/N
  - Salter ..... [YES] [NO] **IF YES, in working order?** Y/N

**Medical supplies**

12. Thermometer [YES] [NO] IF YES, in working order? [YES] [NO]  
13. Stethoscope  
    -Regular [YES] [NO] IF YES, in working order? [YES] [NO]  
    -Obstetrical [YES] [NO] IF YES, in working order? [YES] [NO]  
14. Otoscope [YES] [NO] IF YES, in working order? [YES] [NO]  
15. Tongue depressor [YES] [NO] IF YES, in working order? [YES] [NO]  
16. Watch/timing device [YES] [NO] IF YES, in working order? [YES] [NO]  
17. Steam sterilizer [YES] [NO] IF YES, in working order? [YES] [NO]  
18. Cooker or stove [YES] [NO] IF YES, in working order? [YES] [NO]  
19. Measuring&mix.utensils [YES] [NO] IF YES, in working order? [YES] [NO]  
20. Cups and spoons [YES] [NO] IF YES, in working order? [YES] [NO]  
21.a. Refrigerator [YES] [NO], If NO, go to question 22  
    b. If YES:  
        Type: Electric: [ ] Kerosene [ ] Gas [ ] Solar [ ] Mixed [ ]  
        Condition: Good [ ] Fair [ ] Poor [ ] Non functional [ ]  
        - Freeze-watch indicator? [YES] [NO]  
        - Thermometer inside? [YES] [NO] Temp: \_\_\_\_\_ °C  
        - Temperature chart? [YES] [NO] If NO, go to Q. 22.c  
        If NO, go to question 21.  
        - In the last 30 days, temperature record up to date? [YES] [NO]  
        - Temperature above 80°C: \_\_\_\_\_ (number of days)  
        - Temperature below 0°C: \_\_\_\_\_ (number of days)  
22. Cold packs ..... [YES] [NO]  
23. Cold boxes ..... [YES] [NO]  
    condition: Good [ ] Fair [ ] Poor [ ] Non-functional [ ]

**Availability of Drugs and Other Supplies the Day of the Survey:**  
**(Circle YES for each item.)**

24. Penicillin tablets/Syrup..... [YES] [NO] Ampicillin/Amox.tab/syr [YES] [NO]  
25. Cotrimoxazole ..... [YES] [NO] Nalidixic Acid [YES] [NO]  
26.a. Chloroquine tabs ..... [YES] [NO] Fansidar [YES] [NO]  
    b. Injectable Quinine ..... [YES] [NO]  
27. Injectable Penicillin ..... [YES] [NO]  
28. Inj. Chloramphenicol ..... [YES] [NO]  
29. Paracetamol ..... [YES] [NO]  
30. Aspirin ..... [YES] [NO]  
31. Tetracycline eye ointment..... [YES] [NO]  
32. Gentian violet..... [YES] [NO]  
33. Iron ..... [YES] [NO]  
34. Vitamin A ..... [YES] [NO]  
35. Mebendazole/Piperazine..... [YES] [NO]  
36. Sterile water/injection..... [YES] [NO]  
37. ORS ..... [YES] [NO]  
38. IV solution/severe dehyd..... [YES] [NO]  
39. Needles ..... [YES] [NO]  
40. Syringes ..... [YES] [NO]  
41. Condoms..... [YES] [NO]  
42. Birth control pills..... [YES] [NO]  
43. Injection Depo..... [YES] [NO]  
44.a Are expired drugs in the health facility? [YES] [NO]  
    b. If YES, which ones?:  
        - Expired medicine: \_\_\_\_\_  
        - Expired medicine: \_\_\_\_\_

<b>Vaccines</b>	<b>Available</b>
45. BCG .....	[N/A] [YES] [NO]
46. OPV .....	[N/A] [YES] [NO]
47. DPT .....	[N/A] [YES] [NO]
48. Measles .....	[N/A] [YES] [NO]
49. Tetanus Toxoid .....	[N/A] [YES] [NO]

50.a Are there expired vaccines in the refrigerator? \_\_\_\_ (1=YES, 2=NO, 9=N/A)

.b **If YES**, which ones?

- Expired Vaccine: \_\_\_\_\_
- Expired Vaccine: \_\_\_\_\_
- Expired Vaccine: \_\_\_\_\_

51. Are frozen vials of DPT or TT in refrigerator? [N/A] [YES] [NO]

52. Rupture of stock in the last 30 days? [YES] [NO]

**If YES :**

Item	Number of days of stock-Outs/last 30 days
Vaccines	
Syringes/needles	
ORS	
Essential Medicines	
Cards/forms	
Family Planning Supplies	

53. Are drugs and other supplies adequately organized and appropriately stored? [YES] [NO]

#### **Documentation and record keeping**

**Are the following items present in the health facility?**

- 54.a Immunization register.....[YES] [NO]  
     b If YES, is it up to date?.....[YES] [NO]
55. Immunization tally sheets.....[YES] [NO]
56. Stock of vaccination/child health cards .....[YES] [NO]
57. Stock of TT/maternal health cards.....[YES] [NO]
58. Stock of essential drugs cards.....[YES] [NO]
59. Notifiable disease report forms.....[YES] [NO]
- 60.a All essential monthly reporting forms.....[YES] [NO]  
     b If YES, is it up to date?.....[YES] [NO]
- 61.a Is a patient register kept?.....[YES] [NO]  
     b If YES, is it up to date?.....[YES] [NO]
62. Number of patients seen in last month: \_\_\_\_\_
63. Number of patients 0-4 seen in last month: \_\_\_\_\_
64. Average No. of patients seen per day: \_\_\_\_\_

**END OF EQUIPMENT AND SUPPLY CHECKLIST**

**ATTACHMENT B**  
**FORMULAS FOR THE IHFA SURVEY**

Indicator # 24                      Data File: ANDOBS03.REC

COMMAND	VARIABLES	NOTES
FREQ	SEVERE	500% (4/8) NOTE: Disregard the 'N/A' responses.

Indicator # 25                      Data File: ANDOBS03.REC

COMMAND	VARIABLES	NOTES
FREQ	PNEUM	50% (12/24) NOTE: Disregard the 'N/A' responses.

Indicator # 26                      Data File: ANDOBS03.REC

COMMAND	VARIABLES	NOTES
FREQ	DIAR01	60% (6/10) NOTE: Disregard the 'N/A' responses.

Indicator # 27                      Data File: ANDEXT03.REC

COMMAND	VARIABLES	NOTES
FREQ	KEYMED	67% (24/36)

Indicator # 28                      Data File: ANDEXT03.REC

COMMAND	VARIABLES	NOTES
FREQ	KEYHCM	87% (39/45)

Indicator # 29                      Data File: ANDEXT03.REC

COMMAND	VARIABLES	NOTES
FREQ	KEYWHOME	96% (43/45)

Indicator # 30                      Data File: ANDEQP03.REC

COMMAND	VARIABLES	NOTES
F4		Count manually for the following fields: ORSS <b><u>or</u></b> ESSDRUG to see which health facilities have experienced a stockout in <b><u>either</u></b> ORS <b><u>or</u></b> essential medicines. Result: 100% (4/4)

Indicator # 33                      Data File: ANDEQP03.REC

COMMAND	VARIABLES	NOTES
SELECT	FACTYP = "BHC"	
FREQ	FACTYP	This will provide the denominator (4).
SELECT	FPTRAIN1 = "Y"	
SELECT	CNDM = "1"	
SELECT	ORAL = "1"	
SELECT	INJEFP = "1"	
FREQ	INJEFP	This will provide the numerator (3), resulting in 75% (3/4).

## **ANNEX 2. REPORT OF BASELINE ASSESSMENTS**

### **D. IFHA Report: Jawzjan Province**

*Provincial Strengthening in Northern Afghanistan:  
Capacity Building and Innovation to Support Afghanistan's Basic Package of  
Health Services and Sustainably Improve Access, Quality and Use of Essential  
MCH Services throughout Jawzjan Province*

Cooperative Agreement No. GHS-A-00-03-00011-00  
September 30, 2003 - September 30, 2008

## **Afghanistan CS-19 Baseline IHFA Report Jawzjan, Afghanistan**

Prepared by

Save the Children/US

January 2004

## TABLE OF CONTENTS

### Acronym List

I.	Findings.....	4
A.	Project Indicators.....	4
B.	Observation Checklist – Sick Child.....	5
C.	Exit Interview – Sick Child .....	9
D.	Health Worker Interview.....	12
E.	Equipment and Supplies Checklist.....	16
II.	Summary Conclusions and Recommendations.....	19
III.	Attachments	
A.	Questionnaire in Dari and English	
B.	EPI INFO 6.04 Formulas for Calculating Program IHFA Indicators	
C.	List of Survey Participants	
D.	Email Communication on Indicator 32 Related to MNC Quality Index Score	

## ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ARI	Acute Respiratory Infection
BCG	Bacille Calmette-Guerin
BHC	Basic Health Center
C	Celsius
CDD	Control of Diarrheal Disease
CFR	Case Fatality Rate
CHC	Community Health Committee
CHW	Community Health Worker
CS	Child Survival
DIP	Detailed Implementation Plan
DPT	Diphtheria Pertusis Tetanus
EPI	Expanded Program of Immunizations
FGD	Focus Group Discussion
FP	Family Planning
HFA	Health Facility Assessment (Interchangeable with IHFA)
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
IEC	Information, Education and Communication
IHFA	Integrated Health Facility Assessment (Interchangeable with HFA)
IUD	Intrauterine Device
IV	Intravenous
KPC	Knowledge Practice and Coverage (Survey)
LAM	Lactational Amenorrhea Method
MCH	Maternal Child Health
MOH	Ministry of Health
NGO	Non Governmental Organization
OPV	Oral Polio Vaccine
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
SC	Save the Children
TBA	Traditional Birth Attendant
TT	Tetanus Toxoid
VITA	Vitamin A
WRA	Women of Reproductive Age

## I. FINDINGS

### A. PROJECT INDICATORS

The following table presents the baseline rates and the proposed targets for the project's ten IHFA-related indicators.

#	End of Project Targets/Indicators	Baseline	Target	Data Source/Notes
24	80% of severely ill <5's classified correctly in CS-19-supported facilities (HFA#14, needs clinical validation).	0% (0/19) <sup>19</sup>	80%	JAWOBS03.REC
25	80% of <5 pneumonia cases treated correctly in CS-19-supported facilities (clinical validation during survey).	30% (25/83)	80%	JAWOBS03.REC
26	80% of <5 diarrhea cases treated correctly in CS-19-supported facilities (clinical validation during survey).	35% (8/23)	80%	JAWOBS03.REC
27	60% of caretakers of <5's receiving oral drugs know how to administer all essential drugs at home (HFA #25).	26% (22/86)	60%	JAWEXT03.REC
28	60% of caretakers of <5's know at least 2 aspects of home care (Exit interview - BASICS HFA indicator #26).	59% (64/109)	60%	JAWEXT03.REC
29	60% of caretakers of <5's know at least 2 signs of when to return if child gets worse (BASICS HFA indicator #27).	66% (71/108)	60%	JAWEXT03.REC
30	10% of CS-19 supported facilities had 1/more stock-out of ORS or essential drugs last month (HFA indicator #28).	21% (3/14)	10%	JAWEQP03.REC
31	90% of CS-19-supported facilities achieve perfect EPI quality index score. <sup>20</sup>			
32	___% of CS-19 supported facilities achieving ___ MNC quality index score. <sup>21</sup>			
33	100% of BHCs have FP-trained female health worker posted & 3 birth spacing methods in stock.	30% (3/10)	100%	JAWEQP03.REC

The findings presented here follow the general format of the assessment tool used, the USAID/BASICS Integrated Health Facility Assessment, which is in four components:

5. Observation Checklist – Sick Child
6. Exit Interview – Sick Child
7. Health Care Worker Interview
8. Equipment and Supplies Checklist

<sup>19</sup> This rate is being recomputed based on a review of the Observation Checklist questionnaires in the field.

<sup>20</sup> See Recommendation R9 at the conclusion of this report.

<sup>21</sup> See Recommendation R11 at the conclusion of this report.



## B. OBSERVATION CHECKLIST – THE SICK CHILD

This questionnaire focuses on assessment of health worker skills in diagnosis, medication, treatment, and health education for care of the sick child. The examinations of 109 infants and children under the age of five years who presented at health facilities with fever/malaria, cough/difficulty breathing/pneumonia, or diarrhea/vomiting were observed between December 7 and 10, 2003. This care was provided by 91 physicians, eleven health assistants, six nurses, and one pharmacist working at the following types of health facilities:

<b>Number of Children Observed by Facility Type</b>	<b>Frequency (N = 109)</b>	<b>Percent</b>
BHC	59	54%
Hospital	26	24%
Health Post	10	9%
CHC	9	8%
MCH	5	5%
<b>Total</b>	<b>109</b>	<b>100%</b>

Of the children being brought to these facilities, 78% (85/109) were experiencing difficulty breathing/cough/pneumonia, 55% (60/109) had fevers, and 32% (35/109) were experiencing diarrhea/vomiting. This probably reflects the seasonality of these diseases, with ARI symptoms increasing in the colder months and conversely, diarrhea and malaria increasing during the warmer months.

The initial assessment tasks are not being carried out consistently, with 51% (55/109) of the children having their age checked, 2% (2/109) being weighed and having their weight plotted on a growth chart, and 13% (14/109) having their temperature taken. Few health workers are asking caregivers whether the child has been experiencing the most common danger signs:

<b>Health Worker Assessment of Danger Signs</b>	<b>Frequency (N = 109)</b>	<b>Percent</b>
Vomits everything	30	28%
Not able to drink or breastfeed	24	22%
Convulsions	16	15%
Change in consciousness/ lethargic/sleepy	9	8%

In total, only 6% (6/109) of caretakers were asked about all four danger signs by the health worker and 10% (11/109) were asked about the four main symptoms (diarrhea, ARI, fever and ear problems).

Specific to diarrhea, just under two thirds of caregivers (63% or 69/109) were questioned about whether the child had had diarrhea. Of these, 32% (22/69) were asked about the duration of the diarrhea and 15% (10/69) were asked whether there was blood in the stool. Only 7% (8/109) of children were being observed drinking or breastfeeding, 3% (3/109) had the skin on their abdomen pinched, and 7% (8/109) had their eyes checked to see whether they were sunken. In

sum, out of a total of five history and examination tasks used for assessing diarrhea and dehydration, health workers successfully completed the following number:

<b>Number of Diarrhea-Related Assessment Tasks Completed Per Sick Child</b>	<b>Frequency (N = 109)</b>	<b>Percent</b>
0	74	68%
1	24	22%
2	8	7%
3	1	1%
4	1	1%
5	1	1%
<b>Total</b>	<b>109</b>	<b>100%</b>

Seventy-six percent (83/109) of caregivers were asked whether the child had a cough or difficult breathing and of these, 54% (45/83) were asked about the duration of these symptoms. Fifty-one percent (56/109) of children had their shirt raised so the chest could be examined; 13% (14/109) had their breaths counted; and 17% (19/109) were checked for chest indrawing. Health workers successfully completed the following number of assessment tasks related to the diagnosis for pneumonia and other acute respiratory infections:

<b>Number of ARI-Related Assessment Tasks Completed Per Sick Child</b>	<b>Frequency (N = 109)</b>	<b>Percent</b>
0	35	32%
1	38	35%
2	15	14%
3	17	15%
4	4	4%
<b>Total</b>	<b>109</b>	<b>100%</b>

Sixty-six percent (72/109) of caregivers were asked whether the child had a fever and slightly fewer than half of them (44% or 32/72) asked about its duration. One fourth of children (25% or 27/109) were checked for a generalized rash; 19% (21/109) were checked for a runny nose or red eyes; and only 3% (3/109) were checked for stiffness in the neck, perhaps because this was not malaria season. Health workers successfully completed the following number of assessment tasks related to fever:

<b>Number of Fever-Related Assessment Tasks Completed Per Sick Child</b>	<b>Frequency (N = 109)</b>	<b>Percent</b>
0	58	53%
1	26	24%
2	18	16%
3	6	6%
4	1	1%
<b>Total</b>	<b>109</b>	<b>100%</b>

Very little was being done to identify malnutrition or screen for immunizations. Only 6% (6/109) of children were being undressed and assessed for wasting; 6% (7/109) were being checked for palmer or conjunctive pallor; and 5% (5/109) had their feet checked for edema. In sum, none of the health workers did all three assessment tasks to check for malnutrition. Only one caregiver (1% or 1/109) was asked for a copy of the child's immunization card and none (0% or 0/109) were asked for their own card.

Each child was also examined by Save the Children validators to assess the accuracy of the health worker's classification of the illness and were in agreement with the health workers' diagnosis 29% (32/109) of the time. The health workers identified a total of 149 ailments in these children, of which the validators agreed with 30% (45/149) as noted below:

	<b>Total Number of Diagnosis Made by Health Workers (N)</b>	<b>Agreement on Diagnosis Between Health Workers and Validators</b>	
		<b>Frequency</b>	<b>Percentage</b>
Pneumonia	50	8	16%
Upper respiratory infection (cough/cold)	28	15	54%
Simple diarrhea <sup>22</sup>	23	7	30%
Leishmaniasis	10	4	40%
Acute ear infection	6	1	17%
Bronchitis	6	0	0%
Severe pneumonia	5	3	60%
Dysentery	4	2	50%
Scabies	4	1	25%
Other fever	2	1	50%
Tonsillitis	2	1	50%
Glossitis	2	2	100%
Moderate malnutrition/anemia	1	0	0%

<sup>22</sup> Of the 23 children diagnosed with simple diarrhea, nine were considered to have no dehydration, two with moderate dehydration, and one with severe dehydration, leaving ten children with diarrhea who were not assessed for dehydration.

Very severe febrile fever	1	0	0%
Measles	1	0	0%
Conjunctivitis	1	0	0%
Dermatitis	1	0	0%
Tuberculosis	1	0	0%
Typhoid	1	0	0%
<b>Total</b>	<b>149</b>	<b>45</b>	<b>30%</b>

The validators agreed with the health workers 46% (50/108) of the time in the medicines they prescribed and 27% (29/108) of the time in the overall treatment they provided.

<b>Appropriateness of Medication and Treatment per Diagnosis</b>	<b>Appropriate Medicine Provided</b>		<b>Proper Treatment Provided</b>	
	<b>Frequency</b>	<b>Percent</b>	<b>Frequency</b>	<b>Percent</b>
Diarrhea	9/23	39%	8/23	35%
Pneumonia	39/83	47%	39/83	47%
Dysentery	1/4	25%	1/4	25%

Very little health education appears to be happening during these examinations, with only 35% (38/108) of health workers explaining how to administer medicines/ORS and 14% (15/108) demonstrating how to correctly provide the medicines/ORS. Only 10% (11/108) of health workers asked open-ended questions to verify that the caregivers understood how to administer the medicines/ORS. Fifteen percent (16/109) of health workers explained when to return for followup, only 10% (11/109) told the caregiver that the child should be given more liquids, and 13% (14/109) told caregivers to continue to feed and/or breastfeed at home. Education of caregivers on the signs that would signal the need to return the child to a health facility was being done only minimally:

<b>Education of Caregivers on the Signs Showing Need to Return Child to Health Facility</b>	<b>Frequency (N = 109)</b>	<b>Percent</b>
Child becomes sicker	12	11%
Child develops fever	7	6%
Child develops fast/difficult breathing	6	6%
Child is not able to drink or is drinking poorly	5	5%
Child is not able to breastfeed or eat	4	4%
Child develops blood in the stool	1	1%
Change in consciousness/lethargic	1	1%

In sum, only 8% (9/109) of health workers mentioned three or more of these signs to the caregivers on when it is necessary to return to the health facility. In addition, only 9% (10/109) of health workers took the opportunity to educate caregivers on nutrition.

The average length of the examinations was 8.2 minutes within a range of one to 12 minutes, which provides little time for health education and exploring less readily apparent problems.

### C. EXIT INTERVIEW – THE SICK CHILD

The caregivers of the 109 children observed were interviewed individually shortly after the examinations to assess whether they understood how to give the medicines, and their knowledge of homecare, danger signs, and immunizations as well as care seeking and family planning practices.

A majority of caregivers waited a day or more upon recognition of symptoms before seeking care at a health facility:

<b>Number of Days Between the Recognition of Symptoms and Care Seeking</b>	<b>Frequency (N = 109)</b>	<b>Percent</b>
0	6	6%
1	9	8%
2	17	16%
3	19	17%
4	13	12%
5	14	13%
6	7	6%
7	4	4%
8	2	2%
10	4	4%
12	1	1%
14	2	2%
15 or more	11	11%
<b>Total</b>	<b>109</b>	<b>100%</b>

Each of the caregivers was asked whether their child had received or been prescribed any oral medications during the examination and 79% (86/109) reported they had. The caregivers were asked a series of questions designed to assess whether they knew the correct amount of medicine to give, the frequency of the dose, and the number of days the child was to receive the medicine.

<b>Caregiver Knowledge of Correct Dosage and Timing per Type of Medicine Prescribed/Provided</b>	<b>Frequency</b>	<b>Percent</b>
Chloroquine tablets/syrup	0/0	0%
Antibiotic tablets/syrup	28/50	56%
Aspirin tablets/syrup or paracetamol	13/67	19%
ORS	13/20	65%
Other	8/13	62%

In sum, caregivers knew the correct dosage for 41% (62/150) of the medicines they received. Or, only 26% (22/86) of caregivers knew the correct dosage for each of the medicines they received.

Access to medicines appears to be very good. All 86 caregivers who said they were prescribed medicines were able to get them from the following locations:

<b>Sources for Medicines</b>	<b>Frequency (N = 86)</b>	<b>Percent</b>
This health facility	65	76%
Private pharmacy	43	50%
Another health facility	2	2%
Drug vendor	2	2%

When asked what they would do for their child after returning home, the caregivers responded with the following:

<b>Caregiver Knowledge About Aspects of Homecare</b>	<b>Frequency (N = 109)</b>	<b>Percent</b>
Continue feeding or breastfeeding the child	81	74%
Give the same quantity/more fluids to the child	49	45%
Bring the child back if s/he doesn't get better or gets worse	38	35%
Complete the course of medicines/ORS/RHF	27	25%
Other	5	5%
Does not know	6	6%

In total, 59% (64/109) of caregivers knew at least two aspects of home case-management and 66% (71/108) of caregivers knew at least two signs of the child getting worse as noted below:

<b>Caregiver Knowledge of Warning Signs Showing the Child needs to Return to the Health Facility</b>	<b>Frequency (N = 108)</b>	<b>Percent</b>
Fever begins and does not go away	73	68%
Diarrhea continues	40	37%
Vomiting begins or continues	29	27%
Child has difficulty breathing	29	27%
Child is unable to drink	16	15%
Child has chest indrawing	9	8%
Child is unable to eat	8	7%
Blood in the child's stool	8	7%
Child has convulsions	5	5%
Other	16	15%
Does not know	10	9%

Caregiver knowledge about the benefits of vaccines for mothers and children, specifically what diseases can be prevented by vaccines, was mixed as can be seen in the following table:

Caregiver Knowledge of the Diseases Prevented by Vaccines	Frequency (N = 108)	Percent
Measles	66	61%
Tuberculosis	47	44%
Polio	45	42%
Whooping cough	33	31%
Diphtheria	23	21%
Tetanus	21	19%
Does not know	31	29%

Caregiver knowledge of the number of vaccination visits required for an infant during the first year of life was also relatively low, at 26% (28/107). When asked, 74% (80/108) of caregivers said they knew about side effects associated with immunizations, including the following:

Caregiver Knowledge of Immunization Side Effects	Frequency (N = 108)	Percent
Fever	64	59%
Irritability/crying	49	45%
Swelling	33	31%
Pain at the injection site	16	15%
Other	1	1%

Only 14% (15/109) of caregivers reported being counseled about family planning by the health worker. At the time of the survey, 86% (94/109) of the caregivers were not pregnant. Of them, 61% (57/109) did not want to have another child in the next two years or were not sure. Of these caregivers, 18% (10/57) were not using any family planning method and only 12% (7/57) were using a modern method as noted below:

Use of Family Planning Methods	Frequency (N = 57)	Percent
<b>Modern Methods</b>		
Injections	3	5%
IUD	2	4%
Pills	1	2%
Foam gel	1	2%
<b>Other Methods</b>		
LAM	38	67%
Rhythm	1	2%
Abstinence	1	2%
<b>Not Using Any Family Planning Method</b>		
No FP method used	10	18%
<b>Total</b>	<b>57</b>	<b>100%</b>

## D. HEALTH WORKER INTERVIEW

The leading health professional with responsibility for child health was interviewed at each of the fourteen health facilities surveyed between December 1 and 10, 2003. This included 13 physicians and one nurse. The interviews covered supply sourcing, work related challenges, supervision, staff training, EPI-related knowledge, EPI/ANC services, referral and communication with caregivers.

The health facilities are receiving their main medicines and supplies from NGO (57% or 8/14) and government (43% or 6/14) sources. The majority (79% or 11/14) report that these medicines are delivered and the others are being picked up. Half of the facilities (50% or 7/14) noted there had not been a delay in receiving their supplies and the others listed inadequate transport, administrative difficulties, financial problems, stockouts at the central store, security and climate/seasonal related difficulties as factors leading to delays.

Health workers reported that they face the following challenges in their jobs:

<b>Primary Challenges Faced by Health Workers</b>	<b>Frequency (N = 14)</b>	<b>Percent</b>
Inadequate transport	8	57%
Lack of training	6	43%
Staff shortages	5	36%
Lack of supplies/stock	5	36%
Lack of motivation	5	36%
Poor working environment	4	29%
Caretakers do not bring children to the clinic	2	14%
Low salary	2	14%
Other	2	14%

Ninety-three percent (13/14) of these health workers reported receiving regular supervision, ranging from once a week to once every other month, and 86% (12/14) have discussed the above challenges with their supervisors. Forty-six percent (6/14) of health workers said they had received feedback during their supervision and two thirds of them (67% or 4/6) said it was in written form. In addition, health workers reported that the following activities are regularly covered during supervision:

<b>Activities Covered During Supervisory Visits</b>	<b>Frequency (N = 13)</b>	<b>Percent</b>
Observation of immunization technique	8	62%
Delivered supplies	6	46%
Discussed problems with supplies and equipment	6	46%
Observed management of the sick child	5	38%
Reviewed reports prepared by health worker	4	31%
Updated health worker on current information	3	23%
Other	3	23%



The amount of training received by senior health facility staff appears to be mixed. Only half (7/14) had received any training in the previous twelve months, the topics covering having been: ARI, CDD, polio, and anemia. The majority of these trainings included clinical practice.

Forty-three percent (6/14) of health workers knew the correct immunization schedule for infants. Knowledge on who should receive the tetanus toxoid vaccine was low, with no one mentioning women of reproductive age and fewer than half (43% or 6/14) mentioning pregnant women. The health workers said that TT was provided on the following occasions:

<b>Occasions TT is Provided as Reported by Health Workers</b>	<b>Frequency (N = 14)</b>	<b>Percent</b>
During curative health care visits made by mothers	9	64%
During visits with child for immunizations or treatment	7	50%
During ANC visits	6	43%

Each of the health facilities visited provides immunizations and 64% (9/14) provide ANC clinics weekly:

<b>Number of Days Per Week EPI and ANC are Available at Health Facilities</b>	<b>Immunizations</b>		<b>Antenatal Care</b>	
	<b>Frequency (N = 14)</b>	<b>Percent</b>	<b>Frequency (N = 14)</b>	<b>Percent</b>
One	2	14%	1	7%
Two	2	14%	0	0%
Seven	10	71%	8	57%
Not provided	0	0%	5	36%
<b>Total</b>	<b>14</b>	<b>100%</b>	<b>14</b>	<b>100%</b>

The main reasons why some health facilities are not providing ANC are the lack of training, staff and supplies.

A majority of health workers interviewed (71% or 10/14) said that they had experienced the need to refer a child to the next level of care but were unable to do so for the following reasons:

<b>Reasons Why a Child Could not be Referred to the Next Level of Health Care</b>	<b>Frequency (N = 10)</b>	<b>Percent</b>
Parents did not have enough money	8	80%
No transportation was available	6	60%
Next level of health facility was too far	4	40%
Mother refused to go	3	30%
Lack of fuel	1	10%
Insecurity	1	10%

Eighty-six percent (12/14) of health workers knew at least three signs in a sick child that would require referral to the next level health facility. Knowledge of each sign is noted below:

<b>Signs Requiring Referral of the Sick Child</b>	<b>Frequency (N = 14)</b>	<b>Percent</b>
Child has severe pneumonia	8	57%
Child is lethargic, abnormally sleepy or unconscious	7	50%
Child has severe malnutrition or anemia	7	50%
Child has had convulsions	7	50%
Child has not responded to the usual treatment	6	43%
Child is not eating or drinking	6	43%
Child has severe dehydration	6	43%
Child has a high fever	6	43%
Child looks unwell	5	36%
Child vomits everything	3	21%

When asked what their role is in communicating with caregivers, health workers focused primarily on providing information on prevention, home care, and when it is necessary to bring the child back to the health facility.

<b>Self-Perceived Health Worker Roles in Communicating with Caretakers</b>	<b>Frequency (N = 14)</b>	<b>Percent</b>
Giving information on how to prevent illness	9	64%
Giving information on what to do at home	8	57%
Giving information on the danger signs to watch for	7	50%
Giving information on how to give medicine at home	6	43%
Telling caretakers when to come back to the health facility	4	29%
Finding out what caretakers have done at home and what are the symptoms of the child's illness	3	21%
Giving group talks	2	14%
Ensuring mothers know what to do at home	1	7%

There was very little agreement among health workers when asked about barriers to communicating with caregivers, and a third thought this was not a problem.

<b>Barriers to Communicating with Caregivers about their Children</b>	<b>Frequency (N = 14)</b>	<b>Percent</b>
They do not listen	2	14%
Language barriers	2	14%
Not enough time	2	14%
They do not understand what we say	2	14%
Someone else does it	1	7%
Lack of education materials	1	7%
It is not important	1	7%
Too crowded	1	7%
Not a problem	5	36%

## E. EQUIPMENT AND SUPPLIES CHECKLIST

An inventory was done at the fourteen health facilities to quantify staffing levels, physical infrastructure, equipment, supplies, medicines, vaccines, HMIS materials, and patient levels over the previous month.

In the following table, the number of health workers with child case management responsibilities is compared with the number who were present the day of the survey.

<b>Categories of Health Workers at Facilities</b>	<b>Number Assigned to the Facilities</b>	<b>Number Present the Day of the Survey</b>
Physician/Doctors	28	23
Nurses	23	24
Midwives	14	13
Health Assistants	6	6
Community Health Workers	16	16
Pharmacists	8	7
Vaccinators	33	33

Nearly half of the health facilities (43% or 6/14) reported having at least one female health worker on staff who has been trained in family planning methods.

An inventory of the fourteen health facilities surveyed found the following infrastructure in place:

<b>Health Facility Infrastructure</b>	<b>Frequency (N = 14)</b>	<b>Percent</b>
Adequate seating for patients	8	57%
Covered waiting area	13	93%
Potable water	9	64%
Functional toilet or latrine	12	86%
Functional waste disposal area/pit	10	71%
Health education posters in the local languages on display	6	43%
ORT corner present and in use	7	50%

None of the health facilities have vehicles or motorcycles and only one has a working bicycle. Seventy-one percent (10/14) had a working megaphone, 57% (8/14) have flip charts; and just under half (43% or 6/14) have posters for use in social mobilization. The following table lists the functioning medical equipment and supplies available at the health facilities:

<b>Working Medical Equipment and Supplies Available at Health Facilities</b>	<b>Frequency (N = 14)</b>	<b>Percent</b>
Adult weighing scale	12	86%
Baby weighing scale	11	79%
Salter	10	71%
Thermometer	14	100%
Stethoscope – Regular	13	93%
Stethoscope – Obstetrical	7	50%
Otoscope	10	71%
Tongue Depressor	10	71%
Watch/timing device	4	29%
Steam sterilizer	9	64%
Cooker or stove	11	79%
Measuring and mixing utensils	9	64%
Cups and spoons	8	57%

Specific to EPI equipment, eleven of the health facilities surveyed had a functioning refrigerator (seven gas, two kerosene, one electric and one mixed). Eight of these had a freeze-watch indicator and all eleven had a thermometer. Only seven of the refrigerators with a thermometer had a temperature chart. Eighty-six percent (6/7) of the temperature charts were up-to-date on the day of the survey and two facilities each had records of a single occurrence above eight degrees C and a single occurrence below 0 degree C. Each of the facilities had cold packs and only one did not have a cold box in good condition. All fourteen health facilities reported having all four childhood vaccines (BCG, OPV, DPT and measles) and TT in stock, present in either refrigerators or cold boxes. One facility had an expired vaccine and another had a frozen vial of DPT or TT in its refrigerator.

A visual review of drugs and other supplies found the following present:

<b>Availability of Drugs and Other Supplies at Health Facilities</b>	<b>Frequency (N = 14)</b>	<b>Percent</b>
Penicillin tablets/syrup	7	50%
Ampicillin tablets/syrup	6	43%
Cotrimoxazole	12	86%
Nalidixic acid	3	21%
Chloroquine tablets	13	93%
Injectable quinine	5	36%
Fansidar	3	21%
Injectable penicillin	10	71%
Injectable chloramphenicol	8	57%
Paracetamol	12	86%
Aspirin	13	93%
Tetracycline eye ointment	12	86%
Gentian violet	12	86%
Iron	13	93%

Vitamin A	12	86%
Mebendazole/piperazine	14	100%
Sterile water/injection	10	71%
ORS	14	100%
IV solution	9	64%
Needles	14	100%
Syringes	11	79%
Condoms	7	50%
Birth control pills	6	43%
Injectable birth control	4	29%

Half of the health facilities had expired medicines in stock, including, chloremphenical, doxycycline, FP pills, ORS, aspirin and others. Three health facilities experienced stock outs within the 30 days prior to the survey, including vaccines, essential medicines, cards/forms and family planning supplies. Eighty-six percent (12/14) of facilities had their drugs and other supplies adequately organized and appropriately stored.

Health facilities had the following documentation and record keeping forms available on the day of the survey:

<b>Documentation and Record Keeping</b>	<b>Frequency (N = 14)</b>	<b>Percent</b>
Immunization registry <sup>23</sup>	14	100%
Immunization tally sheet	13	93%
Stock of vaccination/child health cards	13	93%
Stock of TT/maternal health cards	11	79%
Stock of essential drugs cards	9	64%
Notifiable disease report forms	2	14%
All essential monthly reporting forms	12	86%
A patient register <sup>24</sup>	13	93%

Based on a review of the health facility registries, the survey found the following:

<b>Average Patient Load Per Facility Type</b>	<b>BHC (9)</b>	<b>CHC (1)</b>	<b>MCH (1)</b>	<b>District Hospitals (2)</b>	<b>Pediatric Department (1)</b>
Average Number of patients seen in the previous month	336	130	450	724	2,367
Average Number of patients 0-4 seen in the previous month	62	40	122	434	Not available
Average number of patients seen per day per facility	17	5	17	40	100

<sup>23</sup> Only one of the immunization registries was not up to date on the day of the survey.

<sup>24</sup> Only one of the existing patient registries was not up to date on the day of the survey.

## II. SUMMARY CONCLUSIONS AND RECOMMENDATIONS:

***Assessment of the Sick Child by Health Workers:*** The initial screening of children brought to health facilities appears to be very inconsistent, with few assessed for malnutrition, having their temperature taken, having their immunization records checked, or having a basic history taken. While the survey does not address the underlying reasons for this directly, it provides some possible answers. It appears that most of the necessary equipment and infrastructure is available at the health facilities for accomplishing these initial assessment tasks. Health worker knowledge could be a significant factor, based on low levels of knowledge of childhood and maternal immunization schedules and referral signs as well as incorrect diagnosis. Nearly half of the health workers interviewed said that the lack of training was a major challenge they faced in their jobs. And while supervision appears to be happening at most of the facilities visited, only about one forth of the health workers report that they are being updated on current information. An additional factor could also be low motivation, which is difficult to measure in this type of a survey but can be explored through focus group discussions (FGD) with clinic staff.

More specifically, sixty children were brought to health facilities with fever and their examinations were observed during this survey. Only three children were diagnosed with fever by the health workers. One factor that could be contributing to this apparent discrepancy might be that only 13% (14/109) of the children had their temperatures taken (even though each health facility has a working thermometer). It is not clear why so few temperatures were being taken (lack of time, motivation, knowledge, seasonality of malaria, etc.) and why so few fevers were recorded as part of the diagnosis.

Recommendation (R) 1: This situation presents a very clear and direct rationale for the project's focus on increased training and improved supervision of health workers. However, before designing the training program and the new supervisory strategies it is very important to have a more in depth understanding of the causative factors that are leading to these deficiencies within the system. FGDs should be held with health workers, and district level MOH staff and community leaders should be interviewed to better understand the nature of these challenges and the variety of ways that they might be addressed by the project.

R2. The results from the Observation Checklist found that none of the children (0% or 0/19) were correctly classified as seriously ill. (Reference Question Gb or SEVERE.) The original questionnaires need to be reviewed to re-verify these results.

***Educating caregivers on health:*** Important opportunities to provide health education are not being taken at health facilities. Only limited health education is being provided during examinations of sick children, especially in educating caregivers about the correct dosage of medicines, family planning, and danger signs. One reason could be the length of the examinations – averaging 8.2 minutes each – leaving little time to complete the assessment tasks, diagnose, and provide effective health education. Health education during examination might also be considered a low priority for health workers as it is not being covered in supervision and in general, health workers do not seem to perceive many barriers to communicating with caregivers, which could also be read as a lack of interest. Health education also does not appear to be discussed as part of supervision and a majority of the facilities lack health education

materials in the local languages, which together communicate the message that health education is not a priority in patient care. Caretaker knowledge of various aspects of homecare (Objective 28) and danger signs requiring medical care (Objective 29), however, were both relatively strong when compared to their respective targets.

R3. The project needs to explore ways to change the dynamic in the health facilities and possibly within the district level MOH on how they value and support health education in prevention and effective curative care. How can a commitment to ‘no-missed’ opportunities be instilled within health workers so they actively seek out and take advantage of every chance to teach clients and caregivers about health?

R4. Objectives 28 and 29 should be amended or dropped. One option is to increase the number of correct responses required for each from two to three or four, which would substantially decrease the baseline rates.

**Care Seeking Behavior:** Use of BHCs appears to be very low within the project area. And the length of time between the recognition of danger signs and when a child is brought to a health facility in most situations ranges between two to five days. This is especially critical for ARI/pneumonia, where time is of the essence.

R5. The project needs to find out why caregivers delay taking their children to a health facility and also what caregivers are doing during this time to better understand reasons for these delays – self-medicating, seeking traditional healers, going to drug shopkeepers, hoping the illness will pass on its own, low satisfaction with MOH services, seeking approval from the spouse or other family members, etc. This should help to inform the design of an appropriate programmatic response to the problem.

**Immunization:** Vaccines and EPI cards appear to be readily available at the health facilities. However, very few caregivers have cards or report having received them. In addition to the reasons for the low EPI coverage that are listed by the MOH in the KPC report, health worker knowledge of the immunization schedule is very weak and EPI cards for WRA and children are not being checked when they come to health facilities.

R6. The reasons for the breakdown in the EPI card system need to be identified and appropriate responses developed and incorporated into the project DIP.

R7. Training and improved supervision of health workers on EPI needs to be made a program priority, especially on the immunization schedule, filling out/reading the EPI cards, and no missed opportunities.

R8. It is important to get the perspective of caregivers on their perceptions of the efficacy of vaccinations and to see if there are any cultural issues that might be limiting coverage. These can be explored through FGDs with mothers and community leaders.

R9. The indicators and means of verification for measuring the quality index score for EPI need to be developed. (Reference Objective 31.) Some combination of the following indicators appear to fit the situation in Jawzjan and are available from the current IHFA data files:

- The number of health workers who know the childhood immunization schedule.
- The number of health facilities that have up to date temperature charts and no incidents outside the safe range over the previous month.
- Each sick child seen at the health facility has its EPI card checked by a health worker.

**Family Planning Methods:** Half of the health facilities have supplies of condoms and some have pills and injectables. Half of the facilities have at least one female health worker who has received training in family planning methods. However, use of modern family planning methods is reportedly very low, with no one reporting using condoms. Instead, both the KPC and the IHFA found that LAM is the most popular form of family planning.

R10. The project needs to research what is being done to support LAM, especially since it is by far the most popular FP method. Do mothers understand what is required for LAM to work? Why is there only very little interest in modern family planning methods?

**Other:**

R11. The indicators and means of verification for measuring the quality index score for maternal and newborn care need to be developed. (Reference Objective 32.) In a November 6, 2003 email Dr. Winnie Mwebesa suggested, “using the ‘case fatality rate,’ which is the total number of maternal deaths from direct obstetric complications divided by the number of women admitted with these conditions. It is measured in facilities providing comprehensive emergency obstetric care, that is the six basic signal functions (parenteral administration of antibiotics, oxytocic drugs and anticonvulsants, manual removal of placenta, removal of retained products, assisted deliveries) plus obstetric surgery and blood transfusion services. The information can be obtained from facility records and the data needed is the number of maternal deaths within the facility and the number of women diagnosed with one or more of the complications at the facility during the time period. A consensus needs to be reached on the definition of each obstetric complication. The CFR should not exceed 1%. Limitations on the indicator can be found in the Compendium of Indicators for Evaluating Reproductive Health Programs: <http://www.cpc.unc.edu/measure/publications/ms-02-06/5bpartd.pdf> page 18.”

She also suggested other useful indicators that could be drawn from the Service Provision Assessment tool at: <http://www.cpc.unc.edu/measure/publications/tools/cmnht/t6/indicators.pdf>.

These could include:

- Use of the partogram to monitor labor if they are available. This would look at the quality of care during labor.
- Percent of facilities with protocols or guidelines for managing normal deliveries and common complications.
- Percent of facilities offering 24 hour delivery services
- Percent of facilities that report providing c-sections and have all the essential equipment and have skilled personnel for providing c-s.



- Percent of facilities with basic equipment for emergency care of the newborn available.
- Percent of facilities that have a system for reviewing maternal/newborn deaths and "near miss" deaths.

## **ATTACHMENTS**

## 1. OBSERVATION CHECKLIST - SICK CHILD

Province/District: _____	HW Category: _____
Date: _____	Facility Name: _____
Facility Type: _____	Interviewer: _____
Child's age: _____ (months) ID Number: _____	

**Begin Timing the Observation Now. Time:** \_\_\_\_\_

1. What reason does the caretaker give for bringing the child to the health facility? **(CHECK ALL THAT APPLY.)**
  - Diarrhea/vomiting.....[ ]
  - Fever/malaria.....[ ]
  - Difficulty breathing/cough/pneumonia.....[ ]
2. Does the health worker ask of the age of the child or have the age available? Y N
3. a. Is the child weighed? Y N
  - b. Is the child's weight plotted on a growth chart? Y N
5. Is the child's temperature checked? Y N

Does the Health Worker ASK about (or does the caretaker REPORT) -	Does the Health Worker perform these EXAMINATION TASKS?
<b>Danger signs:</b>	
5. Not able to drink or breastfeed? Y N	14. Look for lethargy or unconsciousness? Y N
6. Vomits everything? Y N	
7. Convulsions? Y N	
8. Change in consciousness/lethargic/Sleepy Y N	
<b>9.a Diarrhea?</b> Y N	14. Observe drinking or breastfeeding? Y N
.b For how long? Y N	15. Pinch the skin on abdomen? Y N
.c Is there blood in the stool? Y N	16. Look for sunken eyes? Y N
10.a Cough or difficult breathing? Y N	17. Raise the shirt? Y N
.b For how long? Y N	18. Count breaths/minute? Y N
	19. Look for chest indrawing? Y N
<b>11.a Fever?</b> Y N	20. Look or feel for stiff neck? Y N
.b For how long? Y N	21. Look for generalized rash? Y N
	22. Look for runny nose/red eyes? Y N
<b>12.a Ear problems?</b> Y N	23. Look for pus from ear? Y N
.b Ear pain? Y N	24. Feel for swelling behind ear? Y N
.c Ear discharge? Y N	
.d <b>IF YES</b> , for how long? Y N	
	<b>Malnutrition:</b>
	25. Undress and look for wasting? Y N
	26. Look for palmar or conjunctival pallor? Y N
	27. Look for edema of both feet Y N

<b>A. All danger signs (Q.5 to Q.8 [or Q.13]) assessed?</b>	<b>Y N</b>
<b>B. All main symptoms (Q.9 to Q. 12) assessed?</b>	<b>Y N</b>
<b>C. Number of diarrhea assessment tasks completed? (Circle one.) (History and Examination)</b>	<b>0 1 2 3 4 5</b>
<b>D. Number of ARI assessment tasks completed? (Circle one.) (History and Examination)</b>	<b>0 1 2 3 4</b>
<b>E. Number of fever assessment tasks completed? (Circle one.) (History and Examination)</b>	<b>0 1 2 3 4</b>
<b>F. Nutritional status correctly assessed?</b>	<b>Y N</b>

**Immunization and Screening**

- 28.a Does the health worker ask for the child's immunization card? Y N  
**IF NO, GO TO QUESTION 29.**
- .b **IF YES**, does the child have a card? Y N
- .c If the child referred for vaccination?  
     \_\_\_Today    \_\_\_Another day    \_\_\_Not referred    \_\_\_Up to date
- 29.a Does the Health Worker ask for the caretaker's immunization card? N/A Y N  
**IF NO OR N/A, GO TO QUESTION 30.**
- .b **IF YES**, does the caretaker have the card? Y N
- .c Is the mother referred for vaccination? Y N  
     \_\_\_Today    \_\_\_Another day    \_\_\_Not referred    \_\_\_Up to date

**Diagnosis:**

How does the health worker classify the child?			
30. Simple diarrhea.....[YES] [NO] a. No dehydration.....[YES] [NO] b. Some dehydration.....[YES] [NO] c. Severe dehydration.....[YES] [NO] 31. Dysentery.....[YES] [NO] 32. Persistent diarrhea.....[YES] [NO] 33. Severe persistent diarrhea.....[YES] [NO] 34. Severe pneumonia.....[YES] [NO] 35. Pneumonia.....[YES] [NO] 36. Upper respiratory inf. (cough/cold)                      [YES] [NO]	39. Very severe febrile disease <span style="float: right;">Y N</span> 40. Malaria <span style="float: right;">Y N</span> 41. Severe complicated measles <span style="float: right;">Y N</span> 42. Complicated measles <span style="float: right;">Y N</span> 43. Measles <span style="float: right;">Y N</span> 44. Fever, other cause <span style="float: right;">Y N</span> SPECIFY: 45. Mastoiditis <span style="float: right;">Y N</span> 46. Acute ear infection <span style="float: right;">Y N</span> 47. Chronic ear infection <span style="float: right;">Y N</span> 39. Severe malnutrition..... [YES] [NO] 40. Moderate malnutrition/anemia [YES] [NO] 48. No diagnosis <span style="float: right;">Y N</span> 49. Other diagnosis: _____		

**If validation is performed:**

<b>Ga. Health worker classification agrees with validator?</b>	<b>Y N</b>
<b>Gb. Severely ill child classified correctly</b>	<b>Y N</b>

**Treatment**

What does the health worker administer or prescribe for the child?			
50. Immediate referral? <span style="float: right;">Y N</span> 51. Antimalarial injection <span style="float: right;">Y N</span> 52. Antimalarial tablets/syrup <span style="float: right;">Y N</span> 53. Paracetamol/aspirin <span style="float: right;">Y N</span> 54. Tepid bath <span style="float: right;">Y N</span> 55. Antibiotic ointment <span style="float: right;">Y N</span> 56. Antibiotic tablets/syrup <span style="float: right;">Y N</span> 57. Vitamin A or vitamins <span style="float: right;">Y N</span>	58. ORS <span style="float: right;">Y N</span> 59. Antidiarrheal/antimotility <span style="float: right;">Y N</span> 60. Metronidazole tablets/syrup <span style="float: right;">Y N</span> 61. Tablets/syrup unknown type <span style="float: right;">Y N</span> 62. Injection Unknown type <span style="float: right;">Y N</span> 63. None <span style="float: right;">Y N</span> 64. Other (Specify: _____) <span style="float: right;">Y N</span>		

<b>H.</b>	<b>Is the medication appropriate for the diagnosis?</b>	<b>Y N</b>
-----------	---	------------

<b>I.a</b>	<b>Diarrhea case received appropriate medication?</b>	<b>N/A Y N</b>
<b>I.b</b>	<b>Pneumonia case received appropriate medication?</b>	<b>N/A Y N</b>
<b>I.c</b>	<b>Dysentery case received appropriate medication?</b>	<b>N/A Y N</b>

**If validation performed:**

<b>J.a</b>	<b>Is the child treated correctly?</b>	<b>Y N</b>
<b>J.b</b>	<b>Severe classification correctly referred?</b>	<b>N/A Y N</b>
<b>J.c</b>	<b>Pneumonia case correctly treated?</b>	<b>N/A Y N</b>
<b>J.d</b>	<b>Diarrhea case correctly treated?</b>	<b>N/A Y N</b>
<b>J.e</b>	<b>Dysentery case correctly treated?</b>	<b>N/A Y N</b>

**Interpersonal communication:**

**For all oral medication:**

65 a. Does the health worker explain how to administer medications/ORS? Y N  
 b. Does the health worker demonstrate? N/A Y N  
 c. Does the health worker ask open-ended questions to verify the comprehension of how to administer medications/ORS? Y N

**K. Number of treatment tasks performed?: \_\_\_\_\_ (0 to 3)**

66. Does the health worker explain when to return for follow-up? Y N  
 67. Does the health worker explain the need to give the more liquid at home? Y N  
 68. Does the health worker explain the need to continue feeding or breast-feeding at home? Y N  
 69. Does the health worker tell the caretaker to bring the child back for the following signs?

- Child is not able to drink or drinking poorly Y N
- Child is not able to breast-feed/eat Y N
- Child becomes sicker Y N
- Child develops a fever Y N
- Child develops fast or difficult breathing Y N
- Child develops blood in the stool Y N
- Change in consciousness/lethargic Y N

<b>L.</b>	<b>Are at least 3 of the Q.68 messages circled?</b>	<b>Y N</b>
-----------	---	------------

70. Does the health worker give the caretaker any advice on nutrition? Y N

**Check the time of the observation as the caretaker leaves: Time: \_\_\_\_\_**  
**Duration of observation: \_\_\_\_\_ (minutes)**

## END OF HEALTH WORKER OBSERVATION

- The surveyor may need to ask the health worker about the diagnosis made and the treatment given during the consultation, but only if these two components were not stated during the consultation.
- The surveyor *must complete* this form *before* the next child observation.

## 2. EXIT INTERVIEW - SICK CHILD

Province/District: _____	Date: _____
Facility Name: _____	Facility Type: _____
Interviewer: _____	Child's age: _____ (Months)
Child ID number: _____	

**Greet the caretaker and say that you would like to ask some questions about his/her visit to the health facility.**

2. Did the health worker give you or prescribe you any oral medicines at the health facility today?      Y N

**If NO, go to question 2**

**IF YES,** compare the caretaker's medications with samples for identification of the oral medication.

Complete the table below for the listed oral medications. Fill in the table below by asking:  
**HOW MUCH** medicine will you give the child **EACH TIME**?  
**HOW MANY TIMES** will you give it to the child **EACH DAY**?  
**HOW MANY DAYS** will you give the medicine to the child?

If the caretaker's answer is:

"As required," write AR in the appropriate cell.

"Until completed," writej UC in the appropriate cell.

"I don't know," write DK in the appropriate cell.

Medicine	How much each time?	How many times/day?	How many days?	All correct Yes/No
Chloroquine tablets/syrup				
Antibiotic Tabs/syp Name: _____ Dose/tablets: _____				
Aspirin tabs/syp Or paracetamol Dose/tablets: _____				
ORS				
Other: _____ Dose/tab: _____				

**A. Caretaker knows how to give ALL essential medications correctly?      N/A**  
**Y N**

2. What will you do for your child when you return home? **(CHECK ALL RESPONSES.)**

- Does not know.....[    ]
- Continue feeding or breastfeeding the child.....[    ]
- Give same quantity/more fluids to the child.....[    ]
- Complete course of medications/ORS/RHF.....[    ]
- Bring the child back if he/she doesn't get better or gets worse.....[    ]
- Other: Specify: \_\_\_\_\_[    ]

**F. Caretaker knows at least 2 aspects of home case-management?      Y N**

3. How will you know if the child becomes worse at home and needs to return to a health facility? **(CHECK ALL RESPONSES.)**

- Doesn't know ..... [ ]
- Fever begins or doesn't go away .. [ ]
- Child unable to eat ..... [ ]
- Diarrhea continues ..... [ ]
- Child has chest indrawing ..... [ ]
- Vomiting begins or continues ..... [ ]
- Child unable to drink ..... [ ]
- Child has convulsions ..... [ ]
- Child has difficulty breathing ... [ ]
- Blood in stool..... [ ]
- Other: Specify \_\_\_\_\_ [ ]

**G. Caretaker knows at least 2 signs of child getting worse at home? [YES]  
[NO]**

4. Which diseases will be prevented by the immunizations you or your child has received? **(CHECK ALL RESPONSES.)**

- Don't know [ ]
- Diphtheria [ ]
- Tetanus [ ]
- Whooping cough [ ]
- Measles [ ]
- Tuberculosis [ ]
- Polio [ ]
- Other [ ] Specify \_\_\_\_\_

5.a Do you know what might happen as a side effect after the immunization? Y N  
**IF No, jump to Q 6**

B.If YES, what were you told? **(CHECK ALL RESPONSES.)**

- Fever .....[ ]
- Irritability/Crying.....[ ]
- Pain at injection site.....[ ]
- Swelling.....[ ]
- Other.....[ ] Specify \_\_\_\_\_

6. How many vaccination visits does a child need in the first year of life to complete the series of vaccinations? \_\_\_\_\_ (1=Correct, 2=Incorrect, 9=Doesn't know)

7.a Did your child receive an immunization today? Y N

.b **IF NO**, Was your child referred for vaccination another day? (Prompted question.  
**CHECK SINGLE RESPONSE.)**

- Referred for vaccination another day.....[ ]
- Not referred for vaccination.....[ ]
- Up to date.....[ ]

8. Do you have your child's vaccination card?

- YES.....[ ]
- NO.....[ ]
- LOST.....[ ]
- NEVER RECEIVED.....[ ]
- LEFT AT HOME.....[ ]

If the caretaker has the card, record the dates of ALL VACCINES GIVEN, both today and in the past, and the child's birth date and age

Birth date: \_\_\_\_\_

Age: \_\_\_\_\_ Months

Immunization	Received
Polio-0 (birth)	Y N
BCG	Y N
DPT1	Y N
Polio1	Y N
DPT2	Y N
Polio2	Y N
DPT3	Y N
Polio3	Y N
Measles	Y N

**H. Child is up to date?**

**Y N**

9. Do you have your own vaccination card?

YES.....[ ]  
 NO.....[ ]  
 LOST.....[ ]  
 NEVER RECEIVED.....[ ]  
 LEFT AT HOME.....[ ]  
 N/A.....[ ]

IF YES, copy the caretaker's tetanus toxoid vaccinations in the table below. If the caretaker's TT doses are recorded on the child's vaccination card, copy them here also.

IMMUNIZATION	RECEIVED
TT-1	Y N
TT-2	Y N
TT-3	Y N
TT-4	Y N
TT-5	Y N

**I. Caretaker has received at least TT-2?**

**Y N**

10.a Did you receive tetanus toxoid vaccination today? Y N

.b IF NO, Were you referred for vaccination? (CHECK SINGLE RESPONSE)

Referred for vaccination another day.....[ ]  
 Not referred for vaccination.....[ ]  
 Up to date.....[ ]

11.a Were you prescribed any oral medication at your last visit? Y N

.b IF YES, were you able to get your medicine? Y N

.c IF YES, where did you get your medicine?



This health facility.....[    ]  
 Private pharmacy.....[    ]  
 Another health facility/hospital.....[    ]  
 Drug vendor.....[    ]  
 Other.....[    ]Specify:\_\_\_\_\_

.d **IF NO**, why could you not get the medication?

No drugs available.....[    ]  
 No money/could not afford.....[    ]  
 Other.....[    ] Specify:\_\_\_\_\_

12. Did the Health Worker talk to you about family planning?      Y N

13. Are you currently pregnant?      Y N

IF YES, end the interview.

14. Do you want to have another child in the next two years?

\_\_\_ Yes  
 \_\_\_ No  
 \_\_\_ Not sure

IF YES, end the interview.

15. Are you currently doing something or using any method to delay or avoid getting pregnant?      **IF YES**, what are you doing? (CHECK ALL THAT APPLY.)

___ Norplant	___ Injections	___ Pills	___ IUD
___ Diaphragm	___ Condom	___ Foam Gel	___ T. Ligation
___ Vasectomy	___ Rhythm	___ Abstinence	___ Withdrawal
___ Lactational Amenorrhoea			
___ Other: Specify _____			

**16. How long was it before your child got sick and your visit BHU today?:\_\_\_\_\_**  
**(000=Today, 999=Don't know) #####**

#### END OF INTERVIEW

Thank the caregiver for answering your questions and ask if he/she has any questions.  
 Be sure that the caretaker knows how to prepare ORS for a child with diarrhea, when to return for vaccination, how to give the prescribed medications, and when to return if the child becomes worse at home.

### 3. HEALTHWORKER INTERVIEW

Province/District: \_\_\_\_\_ Health Worker Category: \_\_\_\_\_  
 Date: \_\_\_\_\_ Facility name: \_\_\_\_\_  
 Facility Type: \_\_\_\_\_ Interviewer's name: \_\_\_\_\_

**Introduce yourself to the health worker. Tell him/her that you would like to ask some general questions about the health facility, followed by questions about his/her job.**

1. Where does the health facility usually gets its main medications and supplies? **(CHECK A SINGLE RESPONSE.)**
  - ☐ Government Supplier ☐ NGO Mission
  - ☐ Community Pharmacy ☐ Other SPECIFY: \_\_\_\_\_
  - ☐ Private pharmacy supplier
2. How are supplies usually received? **(CHECK A SINGLE RESPONSE.)**
  - ☐ Delivered to facility ☐ Both
  - ☐ Picked up from the supplier ☐ Other SPECIFY: \_\_\_\_\_
3. What is the most common cause of a delay in delivery of supplies? **(CHECK A SINGLE RESPONSE.)**
  - ☐ Inadequate transport ☐ Insufficient staff
  - ☐ Administrative difficulties ☐ Rupture of stock at central store
  - ☐ Financial problems ☐ Other SPECIFY: \_\_\_\_\_
  - ☐ Insufficient fuel
4. Are you regularly supervised? Y N  
 If NO, go to question 9.
5. Do you have a schedule for supervisory visits? Y N
6. How many times have you had a visit from a supervisor:
  - In the last six months : \_\_\_\_\_ (number of times)
  - In the last 12 months : \_\_\_\_\_ (number of times)
  - Supervisor works here and sees worker daily [ ]
7. What did your supervisor do last time he/she supervised you? **(CHECK ALL THAT APPLY)**
  - ☐ Delivered supplies (fuel, medicines, etc)
  - ☐ Observed immunization technique
  - ☐ Observed management of sick children
  - ☐ Reviewed reports prepared by health worker
  - ☐ Updated health worker on current information
  - ☐ Discussed problems with supplies and equipment
  - ☐ Other: SPECIFY: \_\_\_\_\_
- 8.a Did you receive feedback from that supervisory session? Y N
  - b IF YES, in what form?
    - ☐ Supervisory register ☐ Written Report
    - ☐ Oral report ☐ Other SPECIFY: \_\_\_\_\_

9. What are the most difficult problems that you face in doing your job?  
(CHECK ALL THAT APPLY.)

- ☐ Lack of training
- ☐ Caretakers don't bring children to clinic
- ☐ Lack of time
- ☐ Staff shortages
- ☐ Lack of supplies and/or stock
- ☐ Lack of supervision
- ☐ Lack of feedback on performance
- ☐ Inadequate transport
- ☐ Lack of motivation
- ☐ Poor working environment
- Other ☐ Specify \_\_\_\_\_

10. Have you discussed these problems with your supervisor? Y N

11. How many child-health-related training sessions have you received in the last 12 months? \_\_\_\_\_

**If NO training received, go to Question 14.**

12. What type of training was it? \_\_\_\_\_

13. Did your last training involve any clinical practice? Y N

14. In this health facility at what ages do you give:

(AGES IN WEEKS EXCEPT FOR MEASLES WHICH SHOULD BE IN MONTHS.)

Vaccines	First	Second	Third	Fourth
DPT				
Polio				
BCG				
Measles				

<b>A. EPI vaccination schedule all correct?</b>	<b>Y N</b>
---	------------

16. To whom do you give tetanus toxoid? (CHECK ALL THAT APPLY.)

- ☐ Does not know
- ☐ Pregnant women
- ☐ Women of childbearing age (15-49)

16. On what occasion would you give tetanus toxoid? (CHECK ALL THAT APPLY.)

- ☐ Antenatal clinic visit
- ☐ Visit for curative services of mother
- ☐ Visit with child for immunization or treatment

17. On what days are immunizations given? (CIRCLE DAYS.)

SA SU M T W TH F      Number of immunization days/week: \_\_\_\_\_

18.a Does the health facility have an antenatal clinic? Y N

.b IF YES, on what days is the clinic held? (CIRCLE DAYS.)

SA SU M T W TH F      Number of immunization days/week: \_\_\_\_\_

.c If NO, why are antenatal clinics not held? (CHECK ALL THAT APPLY)

- ☐ Doesn't know
- ☐ No staff
- ☐ No supplies
- ☐ No training
- ☐ No space available
- ☐ Other: Specify \_\_\_\_\_

19. What are the signs that would make you refer a child to the next level of health facility? **(CHECK ALL THAT APPLY.)**

- ☐ Child is lethargic/abnormally sleepy/unconscious
- ☐ Child has not responded to usual treatment
- ☐ Child looks very unwell
- ☐ Child is not eating or drinking
- ☐ Child has severe dehydration
- ☐ Child has severe malnutrition/anemia
- ☐ Child has had convulsions
- ☐ Child has a very high fever
- ☐ Child vomits everything
- ☐ Child has severe pneumonia
- ☐ Other: Specify \_\_\_\_\_

<b>B. Health worker knows at least 3 signs for referral?</b>	<b>Y N</b>
--	------------

20.a Have you ever wanted to refer a child to the next level of health facility but have not been able to do so? Y N

**IF NO**, go to question 21

.b **If YES**, why could you not refer the child? **(CHECK ALL THAT APPLY.)**

- ☐ Next level HF too far
- ☐ No transport available
- ☐ Parents didn't have enough money
- ☐ Mother refuse to go
- ☐ No fuel available
- ☐ Other: Specify: \_\_\_\_\_

21. What do you see as your role in communicating with caretakers when they bring their child to the health facility? **(CHECK ALL THAT APPLY.)**

- ☐ Giving information on danger signs to watch for
- ☐ Giving information on what to do at home
- ☐ Giving information on how to give medicine at home
- ☐ Finding out what caretakers have done at home and what are the symptoms of the child's illness
- ☐ Giving information on how to prevent illness.
- ☐ Telling caretakers when to come back to the H.F.
- ☐ Ensuring that mothers understand what to do at home.
- ☐ Giving group talks.
- ☐ Other: Specify \_\_\_\_\_

22. What prevents you from communicating with caretakers when they bring their child to the health facility? **(CHECK ALL THAT APPLY.)**

- ☐ I don't know how
- ☐ Someone else does it
- ☐ They do not listen
- ☐ Language barriers prevent effective comm.
- ☐ I don't have any education materials
- ☐ It is not important
- ☐ It isn't really my role
- ☐ No time
- ☐ They don't understand what we say
- ☐ Other [ ] Specify \_\_\_\_\_

### **END OF THE HEALTH WORKER INTERVIEW**

<b>Thank the Health Worker for his/her cooperation and answer any questions that he/she may have about the correct recommendations for immunizations or management of sick children.</b>
--

#### 4. EQUIPMENT AND SUPPLIES CHECKLIST (Jawzjan)

Province/District: _____	Date: _____
Facility Name: _____	Facility Type: _____
Interviewers: _____	

Category of health staff **with child case management responsibilities**  
(curative and preventive)

Category	Number assigned to the facility	Number present the day of the survey
Physician/doctor		
Nurse		
Midwife		
Health Assistant		
Community Health Worker		
Pharmacist		
Vaccinators		
Others: Specify		

1. Have any of the female health workers at your facility been trained in family planning methods? ..... [YES] [NO]

##### Patient and Worker Accommodation

2. Is there adequate seating for patients? ..... [YES] [NO]
3. Is there a covered waiting area? ..... [YES] [NO]
4. Is there potable water? ..... [YES] [NO]
5. Is there a functional toilet or latrine? ..... [YES] [NO]
6. Is there a functional waste disposal area/pit? . [YES] [NO]
7. a Are health information posters displayed? ..... [YES] [NO]
- b **IF YES**, Are they written in the local language? [YES] [NO]
8. Is an ORT corner present and being used? ..... [YES] [NO]

##### Equipment and supplies

**Are the following equipment and supplies present in the clinic?**

9. Transportation [YES] [NO] **IF YES, in working order?** [YES] [NO]
  - Vehicle [YES] [NO] **IF YES, in working order?** [YES] [NO]
  - Motorcycle [YES] [NO] **IF YES, in working order?** [YES] [NO]
  - Bicycle [YES] [NO] **IF YES, in working order?** [YES] [NO]
10. Social Mob. Equipment:
  - Megaphone [YES] [NO] **IF YES, in working order?** [YES] [NO]
  - Flip-chart [YES] [NO] **IF YES, in working order?** [YES] [NO]
  - Posters [YES] [NO] **IF YES, in working order?** [YES] [NO]
11. Weighing Equipment
  - Adult weight scale [YES] [NO] **IF YES, in working order?** Y/N
  - Baby weight scale [YES] [NO] **IF YES, in working order?** Y/N
  - Salter ..... [YES] [NO] **IF YES, in working order?** Y/N

**Medical supplies**

12. Thermometer [YES] [NO] IF YES, in working order? [YES] [NO]  
13. Stethoscope  
    - Regular [YES] [NO] IF YES, in working order? [YES] [NO]  
    - Obstetrical [YES] [NO] IF YES, in working order? [YES] [NO]  
14. Otoscope [YES] [NO] IF YES, in working order? [YES] [NO]  
15. Tongue depressor [YES] [NO] IF YES, in working order? [YES] [NO]  
16. Watch/timing device [YES] [NO] IF YES, in working order? [YES] [NO]  
17. Steam sterilizer [YES] [NO] IF YES, in working order? [YES] [NO]  
18. Cooker or stove [YES] [NO] IF YES, in working order? [YES] [NO]  
19. Measuring&mix.utensils [YES] [NO] IF YES, in working order? [YES] [NO]  
20. Cups and spoons [YES] [NO] IF YES, in working order? [YES] [NO]  
21.a. Refrigerator [YES] [NO], If NO, go to question 22  
    b. If YES:  
        Type: Electric: [ ] Kerosene [ ] Gas [ ] Solar [ ] Mixed [ ]  
        Condition: Good [ ] Fair [ ] Poor [ ] Non functional [ ]  
        - Freeze-watch indicator? [YES] [NO]  
        - Thermometer inside? [YES] [NO] Temp: \_\_\_\_\_ °C  
        - Temperature chart? [YES] [NO] If NO, go to Q. 22.c  
        If NO, go to question 21.  
        - In the last 30 days, temperature record up to date? [YES] [NO]  
        - Temperature above 80°C: \_\_\_\_\_ (number of days)  
        - Temperature below 0°C: \_\_\_\_\_ (number of days)  
22. Cold packs ..... [YES] [NO]  
23. Cold boxes ..... [YES] [NO]  
    condition: Good [ ] Fair [ ] Poor [ ] Non-functional [ ]

**Availability of Drugs and Other Supplies the Day of the Survey:****(Circle YES for each item.)**

24. Penicillin tablets/Syrup..... [YES] [NO] Ampicillin/Amox.tab/syr [YES] [NO]  
25. Cotrimoxazole ..... [YES] [NO] Nalidixic Acid [YES] [NO]  
26.a. Chloroquine tabs ..... [YES] [NO] Fansidar [YES] [NO]  
    b. Injectable Quinine ..... [YES] [NO]  
27. Injectable Penicillin ..... [YES] [NO]  
28. Inj. Chloramphenicol ..... [YES] [NO]  
29. Paracetamol ..... [YES] [NO]  
30. Aspirin ..... [YES] [NO]  
31. Tetracycline eye ointment..... [YES] [NO]  
32. Gentian violet..... [YES] [NO]  
33. Iron ..... [YES] [NO]  
34. Vitamin A ..... [YES] [NO]  
35. Mebendazole/Piperazine..... [YES] [NO]  
36. Sterile water/injection..... [YES] [NO]  
37. ORS ..... [YES] [NO]  
38. IV solution/severe dehyd..... [YES] [NO]  
39. Needles ..... [YES] [NO]  
40. Syringes ..... [YES] [NO]  
41. Condoms..... [YES] [NO]  
42. Birth control pills..... [YES] [NO]  
43. Injection Depo..... [YES] [NO]  
44.a Are expired drugs in the health facility? [YES] [NO]  
    b. If YES, which ones?:  
        - Expired medicine: \_\_\_\_\_  
        - Expired medicine: \_\_\_\_\_

<b>Vaccines</b>	<b>Available</b>
45. BCG .....	[N/A] [YES] [NO]
46. OPV .....	[N/A] [YES] [NO]
47. DPT .....	[N/A] [YES] [NO]
48. Measles .....	[N/A] [YES] [NO]
49. Tetanus Toxoid .....	[N/A] [YES] [NO]

50.a Are there expired vaccines in the refrigerator? \_\_\_\_ (1=YES, 2=NO, 9=N/A)

.b **If YES**, which ones?

- Expired Vaccine: \_\_\_\_\_
- Expired Vaccine: \_\_\_\_\_
- Expired Vaccine: \_\_\_\_\_

51. Are frozen vials of DPT or TT in refrigerator? [N/A] [YES] [NO]

52. Rupture of stock in the last 30 days? [YES] [NO]

**If YES :**

Item	Number of days of stock-Outs/last 30 days
Vaccines	
Syringes/needles	
ORS	
Essential Medicines	
Cards/forms	
Family Planning Supplies	

53. Are drugs and other supplies adequately organized and appropriately stored? [YES] [NO]

#### **Documentation and record keeping**

**Are the following items present in the health facility?**

- 54.a Immunization register.....[YES] [NO]  
     b If YES, is it up to date?.....[YES] [NO]
55. Immunization tally sheets.....[YES] [NO]
56. Stock of vaccination/child health cards .....[YES] [NO]
57. Stock of TT/maternal health cards.....[YES] [NO]
58. Stock of essential drugs cards.....[YES] [NO]
59. Notifiable disease report forms.....[YES] [NO]
- 60.a All essential monthly reporting forms.....[YES] [NO]  
     b If YES, is it up to date?.....[YES] [NO]
- 61.a Is a patient register kept?.....[YES] [NO]  
     b If YES, is it up to date?.....[YES] [NO]
62. Number of patients seen in last month: \_\_\_\_\_
63. Number of patients 0-4 seen in last month: \_\_\_\_\_
64. Average No. of patients seen per day: \_\_\_\_\_

**END OF EQUIPMENT AND SUPPLY CHECKLIST**

**ATTACHMENT B**  
**FORMULAS FOR THE IHFA SURVEY**

Indicator # 24                      Data File: JAWOBS03.REC

COMMAND	VARIABLES	NOTES
FREQ	SEVERE	0% (0/19) NOTE: Disregard the 'N/A' responses.

Indicator # 25                      Data File: JAWOBS03.REC

COMMAND	VARIABLES	NOTES
FREQ	PNEUM	15% (9/61) NOTE: Disregard the 'N/A' responses.

Indicator # 26                      Data File: JAWOBS03.REC

COMMAND	VARIABLES	NOTES
FREQ	DIAR01	24% (8/33) NOTE: Disregard the 'N/A' responses.

Indicator # 27                      Data File: JAWEXT03.REC

COMMAND	VARIABLES	NOTES
FREQ	KEYMED	33% (28/86)

Indicator # 28                      Data File: JAWEXT03.REC

COMMAND	VARIABLES	NOTES
FREQ	KEYHCM	59% (64/109)

Indicator # 29                      Data File: JAWEXT03.REC

COMMAND	VARIABLES	NOTES
FREQ	KEYWHOME	66% (71/108)

Indicator # 30                      Data File: JAWEQP03.REC

COMMAND	VARIABLES	NOTES
F4		Count manually for the following fields: ORSS <b>or</b> ESSDRUG to see which health facilities have experienced a stockout in <b>either</b> ORS <b>or</b> essential medicines. Result: 21% (3/14)

Indicator # 33                      Data File: JAWEQP03.REC

COMMAND	VARIABLES	NOTES
SELECT	FACTYP = "BHC"	
FREQ	FACTYP	This will provide the denominator (10).
SELECT	FPTRAIN1 = "Y"	
SELECT	CNDM = "1"	
SELECT	ORAL = "1"	
SELECT	INJEFP = "1"	
FREQ	INJEFP	This will provide the numerator (3), resulting in 30% (3/10).



## **ANNEX 2. REPORT OF BASELINE ASSESSMENTS**

### **E. Report on Breastfeeding Research**

# **REPORT OF RESEARCH FINDINGS BREASTFEEDING AND WEANING PRACTICES IN NORTHERN AFGHANISTAN**

**Andkhoy, Khancharbagh, Qaramqul, and Qurghan districts  
and Jawzjan Province**

#### ***Acknowledgements***

Many people were helpful in making this research and report possible, and Save the Children Federation, Inc. (SC/US) would like to thank them for their assistance. From the Ministry of Health, Dr. Meena and Dr. Rehmatullah. From UNICEF Afghanistan, Felicitie Tchibindat collaborated on developing the tools, Fitsum Assefa commented on the research tools, and Dr. Zakia participated in the research. Special thanks go to the translators, Fraidoon Amel and Najib, and Ahmed-uddin Asim Ta'ibi. Lastly and most importantly, SC/US thanks the communities in Andkhoy, Khancharbagh, Qaramqul, and Qurghan districts, who gave their time and provided us with the answers to our many questions. We hope the findings of this research contribute to improving their children's lives.

This research was conducted as a part of SC/US's Food Security and Nutritional Surveillance project, funded by the United States Office of Foreign Disaster Assistance (OFDA) (HAD-G-00-01-00146-00, September 1, 2001 to April 30, 2003), the purpose of which was to facilitate effective planning, monitoring, and coordination of relief, recovery, and development activities by humanitarian and development assistance actors by providing relevant data on health, nutrition, food security, and other determinants of nutritional status in northern Afghanistan. The findings of the research were presented to the MoH, UNICEF, and other interested agencies in Kabul in April 2003.

SC/US welcomes feedback on this report and its usefulness to other humanitarian and development assistance agencies. This report is produced by SC/US's Afghanistan Field Office staff. The primary investigators were Rolla Khadduri, Dr. Tariq Ihsan, and Dr. Syed Ahmad Gawhary.

## Table of Contents

### ***Background and Introduction***

1. The Research Location—The Andkhoy Area
2. Food and Nutritional Security in the Research Location
3. Previous Breastfeeding and Weaning Research

### ***Methodology***

Demographic Profiles of Interviewees

### ***Findings and Discussion***

1. Most mothers initiate breastfeeding eight to 24 hours after delivery; some breastfeed immediately. Almost half discard colostrum.
2. Exclusive breastfeeding is rare; feeding newborns with water and glucose, non-human milk, other liquids, and soft foods is common
3. Most children under two years of age are breastfed
4. Most mothers breastfeed their babies “many times” a day
5. Most mothers linked their own diet to the quantity and quality of their breast milk and also to child health
6. Some families linked mothers’ health to the quantity of breast milk
7. Some families said that supernatural powers affect breastfeeding
8. “Real” weaning starts when the child is five or six months old; most weaning diets include high-carbohydrate, low-protein foods and foods of little nutritional value
9. Feeding practices make food manageable for babies
10. Family members play important roles in women’s and children’s food consumption
11. Many mothers continue to breastfeed when their child is sick and supplement the child’s diet with soft or milky dishes
12. Most mothers consult their husbands and mothers-in-law when their child was sick, and took them to a clinic
13. Many families use home remedies or other traditional approaches on sick children
14. Use of opium and poppy seed to make babies sleep is common
15. Knowledge and caregiving behaviors probably affected under-two nutrition more than the drought

### ***Conclusions and Recommendations***

1. ***Develop health education/counseling messages about breastfeeding and weaning that take better-understood beliefs and practices into account***
2. Target messages broadly—at mothers, other family members, and influential community members
3. Use local knowledge that supports positive practices in messages and other outreach
4. Challenge/correct misconceptions immediate and exclusive breastfeeding and about weaning foods and offer ways to improve diet diversity
5. SC/US and the MoH should work together to address Andkhoy-specific issues.

## Executive Summary

Since 1996, SC/US has worked in partnership with the Ministry of Health to strengthen the quality and expand the coverage of primary health care services, focused on maternal and child health, in Andkhoy town, its subdistrict Qurghan, and neighboring Khancharbagh and Qaramqul districts in Faryab Province.

In late 2000, SC/US began to respond to the drought in Afghanistan, and through late 2002 (and to a lesser extent, into early 2003) implemented food distribution, nutrition education, income generation, and nutrition and food security surveillance activities in Faryab and Sar-i Pul provinces. In conjunction with its nutrition surveillance activities, SC/US conducted qualitative and exploratory research on breastfeeding and weaning practices for children in the Andkhoy area from August 1 to 14, 2002. Through the study, the researchers sought to learn about breastfeeding and weaning beliefs and practices for children under the age of two, and if and how these practices had been affected by the drought. Although the findings of the study lead to additional questions and topics for investigation in addition to a series of recommendations, they suggest that it will be important to act quickly to identify new—and re-target old—health education messages to improve the nutrition and health of children under the age of two. The study found:

**Breastfeeding is prevalent, but many people do not understand the concepts of immediate and exclusive breastfeeding—with probable negative health effects on children under two.** While we know that newborns should be breastfed as quickly as possible after birth, or at least within the first eight hour, most of the mothers interviewed initiated breastfeeding eight to 24 hours after delivery. Only slightly over half of the respondents fed their newborns colostrum. Some viewed colostrum as dirty or sour milk, or possibly not milk at all, and it seemed that some people made a distinction between feeding a newborn colostrum and breastfeeding (feeding with the thinner white milk that comes two to three days after delivery). Local terminology distinguishes between the two. Family members were influential in supporting breastfeeding practices.

**Exclusive breastfeeding (feeding breast milk with no water or supplementary feeding) is not practiced.** There is no term for exclusive breastfeeding, and most children under four months are fed water, glucose, juice, non-human milk, and soft foods. Bottle feeding is common, which is dangerous in the presence of poor knowledge of bottle hygiene, flies, and a scarcity of water.

**People knew that a child should be breastfed for two years.** However, most mothers who got pregnant discontinued breastfeeding. The common belief was that the breast milk is not safe for the unborn baby as well as the young child.

**People understood that a mother's diet and health affected her breast milk.** Respondents associated eating and drinking more, and eating better foods, with breast milk production. Mothers face diet restrictions in the first 40 days and after that are based on beliefs about the effects of food (generally “hot” effects and “cold” effects) on mothers and children. The restricted diet may affect the health of a mother who is both lactating and recovering from the stress of delivery. Depression and illness were also thought to affect breast milk production.

**While most families felt they started weaning at around five to six months, the introduction of soft foods and juices at a much earlier age suggests that weaning takes place along a longer continuum.** Many weaning diets include foods of limited nutritional value. Children often eat softened versions of family foods that may not include nutritional variety. Many weaning diets include high-carbohydrate, low-protein foods or foods of low nutritional value. In responding to a question about what they had fed

their children in the last 24 hours, mothers mostly reported giving their children boiled water, sugary tea, melon and watermelon, soup, soupy rice with pulses, bread, rice, potatoes, yogurt, and animal or powdered milk, cookies and wheat biscuits. Some mothers commented that they did not have time to make special food for infants. What people fed their children was informed by their perception of the effects of “hot” and “cold” foods.

**Care of sick children often involved continuation of breastfeeding and special feeding. Families took sick children to the clinic, but also used a variety of home remedies based on traditional beliefs.** Most respondents knew that breastfeeding should continue when children were sick, and some sought to increase it. Many families reported that they avoided giving children foods that they perceived as difficult to digest, and they supplemented their sick children’s diets with sweet, milky dishes. Aware that babies experience loss of appetite when they are sick, some reported coaxing the child to eat. Fortunately, many families appeared to know how and when to use oral rehydration solution (ORS) for diarrhea, and others knew to feed vitamin rich fruits to their sick children.

**Child malnutrition probably had as much to do with poor diet practices as it did with the drought.**

While the drought clearly affected people in the Andkhoy area, and respondents told about loss of assets and poorer diets, the research was conducted after the drought had largely broken. The researchers found that children under two still faced poor diet diversity.

## **Recommendations**

- Develop health education/counseling messages about breastfeeding and weaning that take better-understood beliefs and practices into account
- Target messages broadly—at mothers, other family members, and influential community members
- Use local knowledge that supports positive practices in messages and other outreach
- Challenge/correct misconceptions immediate and exclusive breastfeeding and about weaning foods and offer ways to improve diet diversity

## Background and Introduction

This report presents the findings of an exploratory, qualitative study of breastfeeding and weaning practices conducted by Save the Children Federation, Inc. (SC/US) in the Andkhoy area of Afghanistan's Faryab Province between August 7 and 14, 2002.

SC/US is implementing a livelihoods-based food security and nutrition surveillance system in northern Afghanistan. As one activity of the surveillance system, SC/US conducted nutritional surveys in four locations.<sup>25</sup> The results of the surveys showed that acute malnutrition, or wasting, rates were concerning, but not at a level to trigger therapeutic feeding,<sup>26</sup> despite the region's extended drought and its effects on food production and access. However, the survey results clearly showed a higher prevalence of acute malnutrition among younger children (aged six to 29 months) than among older children (aged 30 to 59 months). To explore the reasons behind higher malnutrition in younger children, the surveillance system project included exploratory research on breastfeeding and weaning practices.

The main influences on a child's growth are infant feeding practices, especially breastfeeding and complementary feeding, and exposure to infectious diseases.<sup>27</sup> It is during the weaning period, when the child starts taking nutrition other than breast milk, that malnutrition and growth faltering/growth failure are most pronounced. They can be caused by poor breastfeeding practices, inappropriate timing of complementary food intake, under-nutritious complementary food intake, and infrequent feedings. SC/US nutrition survey results also showed chronic malnutrition, or stunting, rates of around 50%. In the Andkhoy area, SC/US found a global stunting rate of 47.4% [CI: 44.1%–50.8%] using height-for-age Z scores and a severely stunted rate of 22.6% [CI: 19.9%–25.5%] among children aged 0 to 59 months. In Afghanistan, as in many developing countries, chronic malnutrition (and the resulting growth failure that arises in young children) is a matter of public health concern in Afghanistan.

Save the Children conducted this qualitative and exploratory study to learn about breastfeeding and weaning beliefs and practices for children under the age of two, and if and how these practices had been affected by the drought. This qualitative survey was conducted as part of the SC/US food security surveillance system in the Andkhoy area (a cluster of districts including Andkhoy town and surrounding Qurghan subdistrict, Qaramqul district, and Qurghan district) between August 7 and 14, 2002. The objectives of the research were to:

- Improve understanding of breastfeeding practices, especially those related to colostrum, and immediate and exclusive breastfeeding in the Andkhoy area.
- Improve understanding of weaning practices among communities in the Andkhoy area, especially for children between six and 24 months old.
- Explore breastfeeding practices during children's illness.
- Explore whether, and how, the practices above were affected by the drought.

---

<sup>25</sup> Save the Children Federation, Inc., "Nutrition Survey Report: Andkhoy, Khancharbagh, Qaramqul, and Qurghan Districts, Jawzjan Province, June 19-22, 2002"; Save the Children Federation, Inc., "Nutrition Survey Report: Belcheragh District, Faryab Province, Northern Afghanistan, April 7-12, 2002"; Save the Children Federation, Inc., "Nutrition Survey Report: Kohistan District, Faryab Province, Northern Afghanistan, 31 July-9 August, 2002"; Save the Children Federation, Inc., "Nutrition Survey Report: Kohistan District, Sar-i Pul Province, Northern Afghanistan, April 29-May 3, 2002." For additional information on Faryab, see also Medicins Sans Frontier, "Nutritional Survey, Faryab Province, Afghanistan," August 2002.

<sup>26</sup> It is important to recognize that different agencies take different positions on the question of when acute malnutrition should be addressed by health education and when by other responses.

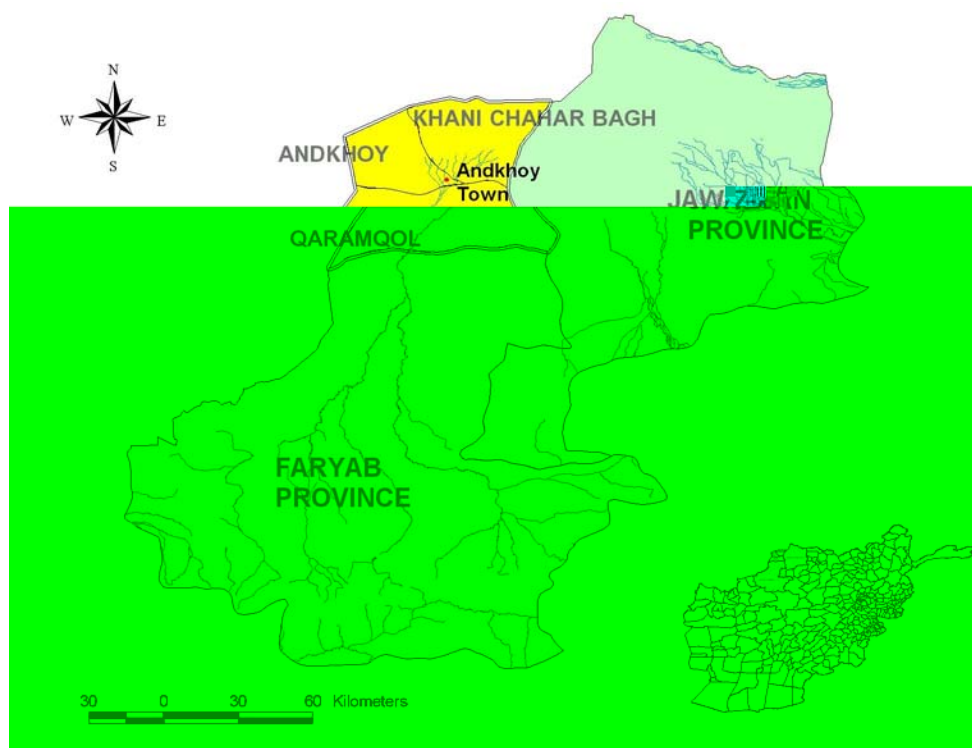
<sup>27</sup> G. Beaton et al, "Chapter 5: Growth monitoring, Individual level – Assessment of Trends", Appropriate Uses of Anthropometric Indices in Children, ed. ACC/SCN (ACC/SCN 1998) 24-36

SC/US will use the findings of this research to help refine health education and counseling messages targeting mothers and caretakers used in primary health care programs in Afghanistan and to inform behavior change strategies that specifically target breastfeeding and weaning practices.

### **The Research Location—The Andkhoy Area**

The four districts of Andkhoy, Khancharbagh, Qaramqul, and Qurghan (hereafter referred to as the Andkhoy area or Andkhoy cluster) are located in the northern part of Faryab Province in northwestern Afghanistan.<sup>28</sup> There are 55 villages in the Andkhoy area. The total population of the four districts is estimated to be 145,608.<sup>29</sup> The population of the Andkhoy area is about 63.5% Uzbek, 33.6% Turkmen, 2.4% Tajik, and 0.5% Pashtun.<sup>30</sup>

Andkhoy town is the one urban center in the area. It is located approximately one and a half hour's drive from the provincial capital of Jawzjan province, Shiberghan, which is a further two hour's drive from Mazar-i Sharif, the main city center in northern Afghanistan. It is much farther away (about 6 hours by road) from its own provincial capital, Maimana. Andkhoy is the first town in Afghanistan when entering the country from Turkmenistan and is a commercial, trading and transport hub.



The Andkhoy area is primarily rural, although the four districts are at the end of an irrigation system and therefore have limited agricultural productivity. The economy in these districts is primarily reliant on the production of carpets, and many women are engaged full time in carpet weaving. Livestock is also an

<sup>28</sup> Currently part of Faryab Province, under some political administrations these districts become a part of Jawzjan Province.

<sup>29</sup> UNICEF uses this figure for national Immunization Days (NIDs).

<sup>30</sup> KPC survey to assess the knowledge and practice of mothers and coverage of key maternal and child health programs conducted by Save the Children Federation, Inc, 1999.

important source of cash as well as food. Agricultural activities in the area include the cultivation of fruits (mostly melons) and fodder, wheat, and sesame.

SC/US has worked in the Andkhoy area since 1996, supporting the Ministry of Health (MoH) in running a primary health care (PHC) program from four clinics in the four Andkhoy districts.<sup>31</sup> People in the area are very aware of the need for health care, and make use of the services available. The goal of the program is to reduce morbidity and mortality of women and children through implementing a comprehensive and cost-effective community-based PHC program. The package of PHC interventions includes treatment for respiratory infections and diarrhea, immunizations, growth monitoring and vitamin A distribution, prenatal care, clean home delivery and access to basic emergency obstetric care (in Andkhoy town), promotion of breastfeeding, and family planning counseling. The health system includes female outreach workers and several female staff members in the clinics.

SC/US has also implemented a microcredit program for women in the Andkhoy area since 1995; most borrowers receive loans for carpet production. In late 2000, SC/US began to respond to the drought with food distribution, cash for work, drought coping loan, and health and nutrition education activities. SC/US distributed WFP wheat and complementary food items (sugar, iodized salt, oil, corn-soy blend, and beans) to 80% of the population in the four districts over a one-year period ending in October 2002.

### **Food and Nutritional Security in the Research Location**

The arid plains of the four districts border Turkmenistan and, like other districts in northwestern Afghanistan, have been affected by the recent years of drought. The World Food Program (WFP), in its Vulnerability Assessment and Mapping (VAM) exercises, identified this area as being significantly affected by the drought in 2000 to 2002.

A comprehensive population-based two-stage cluster survey conducted by SC/US in the four districts in August 2000 showed that 10.9% (95% confidence interval: 8.2 – 14.2%) of children aged six to 59 months in the Andkhoy area were suffering from acute malnutrition and 44.1% (95% confidence interval: 39.5 – 48.7%) of children were suffering from chronic malnutrition.<sup>32</sup> In June 2002, SC/US conducted another two-stage cluster nutritional survey in the Andkhoy area.<sup>33</sup> This survey found a global acute malnutrition rate of 8.7% [CI: 5.9-11.5%] and a severe acute malnutrition rate of 1.7% [CI: 0.7-2.8%] for children aged six to 59 months. It also found that acute malnutrition was notably higher among children of weaning age (6-29 months) than among infants (ages zero to six months) and older children (ages 30 to 59 months). The table below summarizes survey findings for acute malnutrition.

---

<sup>31</sup> Presumably for reasons of proximity, government health programs in the Andkhoy area at the time of research and at the time of finalization of this report, supervised by the Jawzjan Province Ministry of Health structure and not the Faryab Province Ministry of Health structure.

<sup>32</sup> Save the Children Federation, Inc., “Nutritional Assessment Survey Report of Children Aged 6-59 months, District Andkhoy, Faryab Province, Afghanistan,” August 2000

<sup>33</sup> Save the Children Federation, Inc., “Nutrition Survey Report: Andkhoy, Khancharbagh, Qaramqul, and Qurghan Districts, Jawzjan Province, June 19-22, 2002”

### Prevalence of wasting expressed by W/H Z scores by age group

Age group (n)	Severe % (n)	Moderate % (n)	GAM % (n)	≥ -2 Z scores % (n)
0 – 5 months (53)	0.0% (0)	3.8% (2) CI: 1.2 – 8.8%	3.8% (2) CI: 1.2 – 8.8%	96.2% (51)
6 – 29 months (297)	4.0% (12) CI: 1.3 – 6.8%	14.5% (43) CI: 9.9 – 19.0%	18.5% (55) CI: 12.6 – 24.4%	81.5% (242)
30 – 59 months (531)	0.4% (2) CI: 0.1 – 0.9%	2.8% (15) CI: 1.4 – 4.3%	3.2% (17) CI: 1.7 – 4.7%	96.8% (514)
0 – 59 months (881)	1.6% (14) CI: 0.6 – 2.5%	6.8% (60) CI: 4.7 – 8.9%	8.4% (74) CI: 5.8 – 11.0%	91.6% (807)

The survey found a high global stunting rate of 47.4% [CI: 44.1%-50.8%] and a severe stunting rate of 22.6% [CI: 19.9%-25.5%]. The rates found in the Andkhoy area surveys are similar to the malnutrition rates found in other areas of northern Afghanistan where SC/US has conducted nutritional surveys, i.e., chronic malnutrition rates are high, and acute malnutrition rates, while not alarming, are higher for children aged six to 29 months than for children aged 30 to 59 months. Appendix 1 summarizes acute and chronic malnutrition rates from the Andkhoy area and other SC/US nutritional surveys.

Since the highest acute malnutrition was in the weaning age group, SC/US initiated research to explore the quality of breastfeeding and weaning practices and to identify possible causes for acute malnutrition in this age group.

### Previous Breastfeeding and Weaning Research

SC/US was able to identify three pieces of previous recent research addressing breastfeeding and weaning issues in Afghanistan. A 2002 WHO study on issues of breastfeeding and weaning in Kunduz town and the nearby rural Bagh-i Shirkat internally displaced persons (IDP) camp in northeastern Afghanistan involved interviews with mothers who had at least one child under the age of two, mainly focused on 24-hour recall questions about feeding practices.<sup>34</sup> While findings from this study showed some positive practices, such as nearly universal breastfeeding of babies under six months of age and frequent breastfeeding of children up to two years of age, rates of exclusive breastfeeding for children were low.<sup>35</sup> Weaning also appeared to be a problem: interviews indicated that 13% of babies aged six to 10 months in the urban population and 50% in the rural population had not received complementary food in the previous 24 hours. Project interviews also showed that babies were started too early on inappropriate foods (like non-human milk and biscuits), and then were maintained on this diet until about age one. Food with iron and vitamins (such as eggs, pulses, and meat) were rarely fed to babies.

UNICEF and the Ministry of Health (MoH) conducted a joint quantitative and qualitative study on feeding practices in the Panjshir Valley in October 2002.<sup>36</sup> This study found low rates of exclusive breastfeeding (12.5%), frequent giving of colostrum to newborns, and high bottle-feeding use (40% of babies zero to 11 months were bottle-fed within 24 hours of the interviews).

<sup>34</sup> WHO, “A Study of Breastfeeding, Weaning, and Other Mothering Practice in Kunduz”, May 2002.

<sup>35</sup> The percentage of babies under four months who were exclusively breastfed in the last 24 hours were 46.6% in Kunduz town and 56.2% in Bagh-i Shirkat camp, showing that approximately half the infants were not exclusively breastfed. Thirty percent of babies under 10 months in Kunduz and 8.3% of babies of the same age in the Bagh-i Shirkat IDP camp had taken a bottle in the last 24 hours, and 51% in Kunduz town and 14.5% of babies in Bagh-i Shirkat under 10 months had taken a pacifier in the past 24 hours.

<sup>36</sup> UNICEF and Ministry of Health, “Caring Practices Formative Research, Panjsheer Valley Community, Parwan, Afghanistan,” March 2003



SC/US conducted a Knowledge, Practice, and Coverage (KPC) survey in the Andkhoy area in January 2003 using a 30 cluster sampling technique. Respondents were 300 mothers with children 0-24 months of age. Survey results showed an increase in the knowledge of mothers about the importance of immediate breastfeeding with colostrum from 25% in 1999, when an earlier KPC survey was conducted, to 45.5% in 2003. In addition, 30% of respondents knew the importance of exclusive breastfeeding until four months of age, and 20% reported that they did not bottle feed.

## **Methodology**

### **The Approach**

This exploratory and qualitative research on breastfeeding and weaning was carried out in the four districts of the Andkhoy cluster during the week of August 7-14, 2002. It followed a June 2002 SC/US quantitative survey measuring important nutritional anthropometrical indices in the Andkhoy area, and sought further understanding of beliefs and practices related to breastfeeding, supplementary feeding and weaning practices. Given the limited amount of information currently available in Afghanistan on breastfeeding and weaning practices, SC/US chose to use qualitative tools in this research in order to enable in-depth and exploratory questioning accompanied by free-response reporting.

Three SC/US investigators developed qualitative tools in consultation with SC/US health staff and MoH staff, local researchers from the area and UNICEF colleagues – all in Andkhoy. The tools were tested in the field, and subsequently refined; and extensive training and support of researchers were given so the tools were used properly. Following large group meetings with men and women to raise awareness about the research, the researchers used two types of tools—focus group discussions and individual interviews—to collect the data. Respondents were chosen on the basis of convenience sampling, ensuring that each district was equally represented according to population figures.

- Focus group discussions (FGDs): Interviewers conducted discussions with groups of mothers, fathers and grandmothers of children between five months and two years of age to ascertain general trends in feeding practices for young children, obtain local terminology for those practices, and identify issues for further exploration during interviews.
- In-depth interviews (IDIs): From among focus group participants, interviewers identified mothers and fathers with at least one child under two years of age willing to be interviewed in more detail about breastfeeding and weaning practices. These parents were divided into three categories: mothers with a child between zero and four months of age, mothers of children between five months and two years of age, and fathers of children under two years of age. Mothers and fathers were interviewed separately. The question guides focused on breastfeeding practices for the first category, and on weaning practices for the second. The tools were designed to be general guides for researchers, with prompts about issues to probe, rather than as questionnaires that should be strictly followed. Copies of the FGD and IDI tools are included in Appendix 2.

Although the IDIs were intended to involve only one respondent, others were present for most interviews (grandmothers and aunts of the children for the female interview, and other men from around the village for the male interviews). This was impossible to avoid in the cultural context, so researchers were trained to focus on the respondent and to deter others from influencing the respondent by giving their opinions during the interview. Instead, relatives and neighbors were

encouraged to speak after the interview, and their comments were not considered as part of the information gathered. Female researchers were also trained to observe breastfeeding, weaning, and childcare practices, and to note them. The topics they were asked to observe are listed in Appendix 2. Researchers were also trained to observe household assets as a way to classify households in terms of socio-economic status; ultimately, SC/US did not analyze this data due to lack of time.

Because this was qualitative research that required a great deal of understanding and probing of the topic, the investigators invested a great deal of time educating the interviewers about the issues surrounding feeding practices of young children, and in how to ask important follow-up questions.<sup>37</sup> Training and research schedules were adapted during the research process to accommodate interviewer support needs.

### **Conducting the Research**

Interviewed mothers with children younger than four months old were between 19 and 53 years of age, with an average age of 32. They had an average of four children each. Interviewed mothers with children under two years of age were between 22 and 42 years old, with an average age of 31; they also had an average of four children each. Most women were illiterate; a few had attended school, but none for more than six years. Nearly half the mothers interviewed were poor and half from the middle class; only a very few were rich.<sup>38</sup> Most were breastfeeding their babies at the time of the interview. The average age of fathers interviewed was 40 years old, with ages ranging from 25 to 62. Most fathers were laborers or farmers, and a few were shopkeepers or drivers.

In total, the teams conducted 16 FGDs and 69 IDIs. Interview schedules ensured that both Turkmen and Uzbek ethnic groups were represented in the study. In total, 52 qualitative consultations were conducted with Uzbeks and 31 were held with Turkmens. One male FGD had both Uzbeks and Turkmens, and one female IDI was with a Pashtun mother. The table below shows more detailed information about the groups participating in these qualitative consultations.

---

<sup>37</sup> In the course of the research, SC/US learned lessons about the process of doing qualitative research that further qualitative studies should take into account. First, training researchers how to probe is important: investigators found it challenging to train researchers in a qualitative approach, and interviewers seemed to prefer having closed questions to ask, and boxes to check off. Next, intensive follow-up and monitoring in the field during the research process is also important, as is close monitoring of the reporting process directly after the research. (Note: Investigators worked every afternoon with the research teams to ensure accurate reporting and feedback on the research they had done in the morning.) Finally, it is important to build time and resourcing for translations into research projects: accurate translation of materials was difficult and time-consuming, and required extensive checking to ensure a high degree of accuracy.

<sup>38</sup> To determine wealth category, researchers were trained to observe household and other items. As noted in the methodology section, further analysis of this data proved too burdensome to be feasible, given the challenges of translating and checking all of the data.

### Number of focus group discussions and in-depth interviews conducted

	<i>Mothers of children &lt;twoyears old</i>	<i>Mothers of children &lt;4 months old</i>	<i>Fathers of children &lt;2 years old</i>	<i>Grandmothers</i>	<i>Total # of people</i>
<i>Focus Group Discussions</i>	7	0	6	3	16
<i>In-depth Interviews</i>	21	25	23	-	69
<i>Total qualitative consultations</i>	53	25	29	3	85

### The Analysis

Data from the qualitative interviews was post-coded in order to identify themes and gain a sense of the prevalence of particular beliefs or practices. For example, the number of women who reported giving colostrum was noted. This counting is expressed in the results section by the words “many,” “some,” or “a few,” approximately defined as follows:

- Many = more than 70% of respondents
- Some = between 30% and 70% of respondents
- A few = less than 30% of respondents

This report categorized the findings into 15 themes that are discussed in detail. The findings are meant to give insight into breastfeeding and weaning behavior in the Andkhoy area and are not intended to represent breastfeeding practices in other locations in Afghanistan. Because of the seasonal dimension of dietary intake and activities, the extent to which the findings represent breastfeeding and weaning behavior throughout the year.<sup>39</sup>

### Notes on Terminology

The researchers tried to capture specific terminology that would be useful in understanding practices and in developing messages. Where collected, these terms are included in the text of the report.

In this report, SC/US uses the term newborn for children aged 0-40 days, infant for children under one year of age, and child for children aged one year or older.

---

<sup>39</sup> For example, the variety of vegetables and fruits available in the Andkhoy area is seasonal. Fresh vegetables are available between March and June and fruits such as melon and apricots are available during the summer months.

## Findings and Discussion

### 1. Most mothers initiate breastfeeding eight to 24 hours after delivery; some breastfeed immediately. Almost half discard colostrum.

*My mother said that if I put my breast in the baby's mouth, milk would come. Aghuz is good for the baby. They [babies] won't get sick soon; they will grow fast and be strong. It is good for the mother, too, and she has less [abdominal] pain. Aghuz increases the love for the baby.*

A young mother, Andkhoy

*If aghuz comes, we give it immediately to the newborn. Aghuz is force. If we don't give aghuz the boy will not be a boy. If aghuz is given immediately, the baby will become strong.*

An Uzbek mother, Qaramqul

*Mother's milk doesn't come immediately. It was also the same in my two first children. After the birth [of this latest child], the mother's milk came after one day. We know aghuz; it is a little yellow. We haven't given [colostrum] to my three children. Elders of my family say not to give it; they say that aghuz is very powerful and makes a child's stomach hard. One drop of aghuz makes a daig (a cooking pot) of milk hard; that is why we don't give it to our children. My children, thank God, are all healthy. I haven't even taken one to a doctor.*

An Uzbek father, Andkhoy

*All day on the day of delivery, I didn't have milk. I gave glucose because it was my first child and I felt shy about breastfeeding in front of others. When I gave my breast to my child, it didn't have milk—it came after two days.*

An Uzbek mother, Andkhoy

Only a few women reported breastfeeding immediately (within half an hour) after delivery.<sup>40</sup> Some said they initiated breastfeeding within three to five hours of delivery, while the majority started breastfeeding between eight and 24 hours after delivery. (This finding contrasts with an SC/US January 2003 KPC finding that 76% of mothers initiated breastfeeding less than eight hours after delivery; the researchers are unable to explain the contrast and it deserves further investigation.) Just over half of the women fed their newborns<sup>41</sup> colostrum because they felt it to be beneficial for them. A few delayed breastfeeding for up to three days after delivery. A few Uzbek mothers who did not have milk on the day of delivery asked other lactating women in the family to breastfeed their newborns.

---

<sup>40</sup> Immediate breastfeeding has benefits for both mother and newborn. Mother's breasts are thought to be cleaner, and therefore safer, for newborns than other feeding instruments, and the colostrum produced in the first few days after delivery gives a child passive immunity to disease. There appears to be a link between the immediacy of breastfeeding and the success with which a mother and child are able to breastfeed. Immediate breastfeeding is also thought to help the mother through causing uterine contractions that can help to expel the placenta and by reducing maternal blood loss.

<sup>41</sup> Work on identifying Uzbek and Turkmen terms for children of different ages was incomplete in this research. Researchers identified the following Uzbek and Turkmen terms for children in the age group studied:

- Uzbek: for newborns (up to 40 days) *chegha lagh*, *machoogy*, *bacha gina*, *maida bacha*; for children four to six months *elkily*.
- Turkmen: for newborns (up to 40 days) *ba bak*.

Almost all women knew the word for colostrum in their own language (*aghuz* or *fez sooz* in Uzbeki and *filla* in Turkmeni). Of the interviewed mothers with children less than four months of age, just more than half had fed their latest child colostrum. The proportion of women giving colostrum to their newborns in the Andkhoy area was lower than the proportion found by the UNICEF/MoH study in Panjshir, where most women (about three-quarters of the respondents) had given colostrum to their newborns.

Women who gave colostrum to their newborns gave several reasons for doing so. They considered it a “gift of God” and good for the newborn’s healthy growth and development. One Uzbek mother in Qaramqul said, “*Aghuz*, which is the first milk that comes out from mothers’ breasts, gives energy to babies. The color is not similar to normal milk. Old women say that *aghuz* makes a baby strong and is good for their health. It makes the baby’s bones strong and fills it inside.” Many mothers who had given colostrum to their child also mentioned that colostrum increased the bond and love between a mother and her child. A few mentioned that feeding colostrum was good for boys, reduced pain in the mother’s abdomen, and could help stop vaginal bleeding.

Most mothers who gave colostrum did so because they said it was their tradition, and it was a good thing. A few mothers started giving colostrum after receiving education from the clinic staff, e.g., doctors and traditional birth attendants. These women also said they now believed that deaths of previous children has been due to the lack of giving colostrum. One Uzbek woman from Qurghan said, “*The doctor said to give filla when my baby was born at the hospital.*” Some grandmothers and mothers-in-law played an important role in encouraging mothers to give colostrum. In a few cases husbands also encouraged their wives to feed their colostrum to their babies. One Turkmen father mentioned that although he did not know about colostrum himself, he was a farmer and knew that the cow’s first milk was very good for the calf.

Respondents gave a number of reasons for delaying breastfeeding, including beliefs about colostrum, shyness in front of others, pain in breastfeeding, or the belief that breastfeeding without the husband’s permission was prohibited by Islam and that initiation of breastfeeding had to wait until permission was given.<sup>42</sup> This finding is concerning given that colostrum plays a vital role in providing immunity against various life threatening illnesses, specifically measles.

Just under half of the women interviewed discarded colostrum. Many of these women expressed it from their breasts and threw it away on the first day, while a few discarded it after over a period of two or three days. Some considered it dirty and harmful for their newborns—the thickness and the yellowish color of colostrum make some believe that this liquid is dirty and is not proper milk. This perception may be reinforced by language; colostrums is referred to as *aghuz* or *filla*, where as the subsequent breast milk is referred to as *aaaina* in Uzbeki or *karpa* in Turkmeni.

Another common concern was colostrum’s potential effect on newborns stomachs. Some mothers who discarded colostrum believed that it would cause abdominal distension and stomach ache in newborns. Some mothers-in-law reinforced this perception, as did some traditional birth attendants. One Uzbek mother in Qurghan said, “Until three days [after delivery] I did not give my milk; just glucose; and also I mixed soup with water. I squeezed out my *filla* and buried it under a tree. I don’t know whether it has benefits; I heard *filla* makes the baby’s stomach big and it is harmful. That is why I didn’t give it to my baby.”

Some fathers believed that colostrum had the power to coagulate breast milk in a small child’s stomach and make it very hard. Others, both Turkmen and Uzbek, believed that colostrum was dirty because the milk had rotted in the breasts for many months during pregnancy and become sour. They believed this

---

<sup>42</sup> The belief that permission must wait for the husband’s permission was found in a few Uzbek women.

was more common among those women who baked bread everyday and exposed themselves to a hot oven than among those who do not bake bread. One father said, “*Aghuz* is dirty and if a child drinks it, s/he gets a skin infection. The mother’s breast during pregnancy remains close to the flame of a *tanoor* (oven) several times in a day. We think if a mother who has milk in the breast gets near a *tanoor*, it [colostrum] gets hard – like milk turns into yogurt when kept warm. It is because of this that every time a [pregnant] mother bakes bread she squeezes some of the *aghuz* and pours it in the river.”

Another reason for discarding colostrum commonly mentioned by some Uzbek and Turkmen parents was that it could cause neonatal tetanus (*haftak*). Some women delayed breastfeeding for several hours for this reason. Among these, some waited for their babies to get vaccinated against *haftak* before breastfeeding.<sup>43</sup> A few had stopped giving colostrum because they believed it caused *haftak* in their newborns, and killed them. One Turkmen father in Andkhoy said, “We don’t give *aghuz* to babies. I have four children and we only gave *aghuz* for my first child, who died of *haftak*. My other children did not drink *aghuz*. The women say that *aghuz suti* (feeding colostrum) is not good for the baby. We were giving it [colostrum] before, but now we don’t.”

Delay in breastfeeding, coupled with failure to give the newborn colostrum, affects the newborn’s chances of survival in the first vulnerable hours after delivery and makes it more difficult for the mother to breastfeed afterwards. It also implies that the bonding – biological, physical and emotional – between mother and newborn is not recognized.

**2. Exclusive breastfeeding is rare; feeding newborns with water and glucose, non-human milk, other liquids, and soft foods is common.**

*If the milk is enough, we don’t give any thing else except the mother’s milk, because it is the best food. If they [babies] take mother’s milk, they will dance like small sheep.*

A Turkmen father, Khancharbagh

*In a focus group discussion, one woman said, “My milk has everything. Even if he becomes thirsty, I give nothing else, because my milk has water.” Another woman replied, “This practice is not usual. Giving only milk and no water is impossible!” All the other participants agreed with the second woman.*

Focus group, Qurghan

*All day [on the day of delivery] I did not have milk; I gave glucose because this is my first child and I felt shy [to breastfeed in front of others]. When I gave my breast to my child, I didn’t have milk; it came after two days.*

A young Uzbek mother, Andkhoy

*I gave water of watermelon and one time kulcha (biscuit). I gave my milk to her at night and before sleep. Whenever she wakes up I give [breast milk]. I also give boiled water in a glass because the weather is hot and her mouth becomes dry, also her lips. That is why I give water.*

A mother, Qaramqul

---

<sup>43</sup> At birth, newborns receive BCG vaccinations from health staff at the clinics or during health outreach.

*The clinic staff teach us that breast milk until four months is enough. We give boiled water because of hot weather at least one or two times a day.*

An Uzbek mother, Andkhoy

*Breasts are clean, the milk of the mother is ready and easy to give, and there is no problem. Joshak (bottles) are dirty and give children diarrhea. Powdered milk is very expensive.*

A Turkmen mother, Khancharbagh

This study found that cases of exclusive breastfeeding were rare in the Andkhoy area.<sup>44</sup> There are no local terms for exclusive breastfeeding in either the Uzbeki or Turkmeni languages/cultures in the Andkhoy area. Knowledge about the importance of exclusive breastfeeding was poor among most interviewees; almost none understood the concept.

Only a couple of Uzbek families exclusively breastfed their newborns until they were 40 days old (the first 40 days after delivery is known as the *chilla* period),<sup>45</sup> without giving any water. Instead of being fed the nutritious first milk of the mother, many newborns survived on pharmaceutical glucose, water, and sugar/water solutions for several hours to several days after birth until breastfeeding was started. Some Turkmen and Uzbek mothers believed that breast milk was produced on the third day after delivery. Only a few Uzbek mothers in Andkhoy knew that exclusive breastfeeding was good for the infants, and that it also helped the mother avoid pregnancy for a while; they had learned this from health clinic staff. Despite this knowledge, these same mothers were giving boiled water to their infants.

Most mothers with children younger than four months were breastfeeding at the time of this research and, in addition, almost all were giving water and supplementary food, mostly because they did not want their children to be hungry or thirsty. The results of this study are comparable with the results from the WHO and UNICEF/MoH studies, which also found low exclusive breastfeeding rates.

Almost all families fed their newborns pharmaceutical glucose, sugary water solutions (*nabat*) and water in the first few days after birth. Most respondents gave their newborns water two to four times a day. Although giving newborns water and glucose was more common among mothers who delayed breastfeeding, mothers who initiated early breastfeeding also gave glucose and other liquids besides breast milk to stop newborns from being hungry, or because they had seen it done or been advised to do so by the clinic. An Uzbek mother-in-law in a focus group

---

<sup>44</sup> WHO recommends that a child be exclusively breastfed for the first four to six months of life, and states that breast milk is enough to meet the caloric and fluid needs of the newborn during this period.

<sup>45</sup> This is a period of uncleanness for the mother (she cannot bathe, pray, or prepare food) and of vulnerability for both the mother and the newborn. Mothers and newborns need to rest and be protected from *nazar* (the evil eye), and newborns are also vulnerable to disease. The mother and baby stay home—perhaps in a room in which *asfand* (an herb) is periodically burned to ward off the evil eye. Mothers often eat a special restricted diet. Some mothers, generally those who are older, already have children, and have more control in the household, bathe and return to their normal duties after about ten days.

discussion said, “*The clinic told us to give glucose for three days so the babies are not hungry.*”<sup>46</sup>

Almost all infants under four months were given boiled water with a cup, spoon, bottle, or from a plastic bag with a small hole in one corner. The mothers gave water because they believed that breast milk was not enough to quench the thirst of the infants, especially in hot summer months (*cheetagh* in Uzbeki). Most families boiled water to make it softer and less *baadi* (gaseous) in order to avoid abdominal distension and stomach ache among babies.<sup>47</sup> A few well-off Uzbek women bought mineral water (*aabi madani*) in the bazaar for their babies.

Bottle feeding was low among mothers who had ample breast milk. About one third of interviewed mothers with infants younger than four months old had given them powdered or other non-human (goat or cow) milk (not formula) using a plastic bottle with a nipple, a practice supported by some mothers-in-law. Most women knew that breast milk was best; but, because they had problems in nursing and producing their own milk, some felt they had to give powdered milk, despite the expense and inconvenience. A few poor respondents said their families had sold wheat or other grain to buy powdered milk and bottles. A few women made the connection between giving the child bottled milk and then having less milk themselves, but not many.

In the words of one Uzbek woman from Andkhoy, “*If the child drinks my own milk, he would get fat soon. But he cannot take my breast. When I give powdered milk, the child cries until I prepare it, and [so] I can’t sleep nights. If he took my breast, I would not waste this much expense.*” Another Uzbek woman from Qaramqul said, “*My milk is good now. I gave animal milk to my other children because my milk was not so much. Now [at the time of a good harvest] I don’t give animal milk.*”

The high use of bottled milk for infants less than four months is especially problematic in a dry place like Andkhoy, where knowledge about bottle hygiene is poor, clean water is scarce, and flies are prevalent, especially in the summer months. Interviewers observed that almost all the mothers who gave their infants powdered milk had enlarged the hole in the bottle nipple so it became easier for the infant to suck. Interviewers also observed that the plastic bottles and nipples were not cleaned properly. Several of the mothers whose children were bottle-fed complained of the child having diarrhea and malnutrition. One Turkmen mother in Andkhoy said, “From the day she was born, she was sick. She did not take my milk and my breasts dried up. Every day she has been sick with diarrhea. When she’s sick, she doesn’t eat anything, not even powdered milk. I give her everything, but if she doesn’t want it, I don’t push her.” Some mothers were opposed to bottle feeding because they considered it dirty and a source of illness for their children. Among them, many used spoons to feed newborns supplementary liquids.

In addition to water, glucose, and non-human milk, interviews revealed that most mothers fed their one-to-two month-old infants other liquids and soft foods such as soup, watermelon juices, and biscuits softened with sauce (*kulcha*) or soup, a practice supported by most mothers-in-law. When infants are between three and four months old, families added potatoes, cereal, and “soft” (*luhab*) food such as stew sauces. In most cases, infants were fed with supplementary food at least twice a day. Beliefs about the effects of “soft” and “hard” foods influenced what mothers fed their infants under four months (the concepts of “soft” and “hard” seem to incorporate both texture and some conception of

---

<sup>46</sup> The research did not probe into why the clinics recommended giving glucose to newborns, but one casual comment indicated that clinic staff may see it as useful in treating newborn jaundice. The question of infant hunger must be explored further.

<sup>47</sup> The water in Andkhoy tastes salty.



digestibility/tendency to produce gas). Some Uzbek mothers felt that soft food caused abdominal distension and stomachache in newborns and should be delayed until a child was four months old; a few Turkmen mothers mentioned the same symptoms for hard foods. Some poor families could not feed what they perceived to be good food (biscuits, meat broth, watermelon juice) to infants because they could not afford to.

The researchers found that in some cases, husbands played an important role in decisions about giving additional food or water to babies. A few Turkmen mothers in Khanecharbagh said they wanted to use bottles to give their babies water because it was easier, but their husbands would not permit it, while some Uzbek husbands in Qurghan would not allow their wives to give babies additional food because they believe that breast milk is good for babies' growth and development, or for fear that the child would develop diarrhea. A few fathers said that they believed feeding breast milk only for the first four months was best for babies, but that after their wives had died a few months after delivery, their babies were fed soft foods.

### **QARAMAT'S STORY**

Powdered milk is readily available in Andkhoy area bazaars, but is expensive relative to the incomes of most interviewees. In addition, since powdered milk *is* expensive, and animal milk is not always available, families tend to use smaller amounts of milk powder than specified, and to dilute the milk with too much water, a practice which can easily lead to early malnutrition. The following case study illustrates this point.

Qaramat lives in a typical Turkmen high-domed mud room, in Qurghan district. She is 38 years old, and had recently given birth to twin sons when the research team met her. The 45-day old twins lay in separate cribs made of sacks and ropes and hanging on opposite sides of the room. As the interview progressed, it became clear that Qaramat did not breastfeed her twins. She said she had no milk. She said she had rarely had milk for her other children either. Two of her older children were sleeping in the room, and the other five had died. The crying of the twins became louder and louder as the interview progressed, and Qaramat responded to this by rocking their sack-cribs. Her sister came in the room, and started preparing their meal: half a teaspoon of powdered milk, a sugar cube, and some boiled water in a dirty bottle whose nipple hole had been enlarged. As she fed this mixture to one twin, she gave the other a pacifier.

The researchers (one of whom is a doctor) asked to examine the boys, and realized that they were very malnourished and dehydrated. The doctor asked Qaramat if she was sure she had no milk. She insisted, but on examination, it seemed that she was still producing milk from both breasts. The researchers decided then to abandon the interview, and began counseling her about breastfeeding. She took one infant to her breast, and held it in the wrong position (not laying across her lap, but instead almost standing) and carried on rocking it as it cried. The researchers advised her on easier positions to breastfeed, and stayed with her until she had fed both twins for at least 15 minutes each. She had enough milk to do so. The researchers encouraged her to drink plenty of tea (tea is commonly consumed compared to water) and eat plenty of food herself to improve her milk supply. They also advised her not to feed the infants any more powdered milk, especially since Qaramat was poor and was complaining about how expensive the powdered milk was. Qaramat said her family had actually sold their complementary food rations distributed from the clinic to pay for the powdered milk.

Five days later, the researchers returned with a female community health outreach worker from the local clinic to check on Qaramat. The twins looked much healthier, and Qaramat proudly

demonstrated how she was breastfeeding them both. But she was still also bottle feeding them powdered milk. The community health outreach worker followed up on giving her advice, and the male community health outreach worker spoke to her husband. They brought the twins to the hospital after 15 days to get them weighed and checked. The twins were quite low weight, but they were no longer malnourished and dehydrated.

NOTE: A visit some months later revealed that one of the twins had died of an acute respiratory infection, but the second one was doing fine, relatively speaking.

### 3. Most children under two years of age are breastfed.

*Aaina suti (breastfeeding) is better for two to two-and-a-half years or until the mother becomes pregnant. Girls must be breastfed more than boys.*<sup>48</sup>

A Turkmen father, Qaramqul

*When a woman is four months pregnant her milk changes. The color becomes stronger and becomes harmful for a baby—whether a girl or a boy. If I become pregnant again, I will stop breast-feeding and will save my milk for one year.*

A Turkmen woman, Khancharbagh

*My mother-in-law says that when I have a daughter in my womb, then the milk is not good for the son [pointing at the child in her lap].*

An Uzbek woman, Qaramqul

Most respondents knew that children should be fed breast milk until they were two years old, and did so. A few Turkmen families added that breastfeeding should continue for more than two years. (Interviewers observed this practice during the qualitative consultations when a young child cried, even if it was older than two years, the mother would put the child to her breast.) Most believed that breastfeeding was good for a child's growth and development, saying that it made him/her strong, especially in the bones. While most family members said they received information about breastfeeding from health clinic staff, some mentioned that *mullahs* (religious leaders) recommended breastfeeding babies for two to three years.

Mothers breastfed fed their babies whenever they cried, many times a day, from both breasts. Most mothers and family members knew that mothers should eat more when they were breastfeeding, and most mothers did so. Observations showed that some mothers did not know how to breastfeed properly, and so thought they did not have enough milk. A few mothers with little breast milk asked other lactating mothers in their neighborhoods to breastfeed their babies for them.

The main reason for stopping breastfeeding before the child turned two was because the mother became pregnant again. Many women said that they would stop breastfeeding their child under two if they became pregnant again, although a few Uzbek mothers continued to breastfeed even while five-to-six months pregnant. A few interviewed women were already pregnant again, and had stopped breastfeeding. Many families believed that once a woman was pregnant, breastfeeding would harm the unborn baby (especially boys, according to some), and also sometimes the young child. Many husbands also mentioned that mothers should breastfeed as long as they had milk or until the next pregnancy. One

---

<sup>48</sup> This is a reference to Islamic teachings that boys should be breastfed for two years and girls for two and a half years.

Uzbek mother in Qaramqul said, *“I give breast milk until I know I am pregnant. When the baby moves (inside) I know I am pregnant. I cut off my milk; otherwise it is harmful for the [breastfeeding] child.”*

Some mothers mentioned that they breastfed *sheer-ba-sheer* (from one child to the next) with no break. A few mothers breastfed both the newborn and the previous child. One Turkmen mother in Andkhoy said, *“I give milk for two or three years, or I give milk until the next pregnancy. I bear children one after the other. I separate (wean off) one child from milk and then take another.”*

#### **4. Most mothers breastfeed their babies “many times” a day.**

*I give milk ten times in the day and three times at night. When the child is crying, I know he’s hungry. When my child cries, I use my breast to keep him quiet. I don’t have any other way of making the child rest. When I breastfeed, I put the child to my breast for less than one hour. I give milk from both breasts so that his stomach fills.*

An Uzbek woman, Qaramqul

Of the interviewed mothers who were breastfeeding at the time of the survey, most breastfed their children under two years of age many (five to eight) times a day, and each time for more than half an hour. Many mentioned they breastfed every time a child cried (day or night), a practice that was also observed during the qualitative consultations. Most mentioned that they breastfeed from both breasts to ensure that a child was full and to ensure each breast was empty; some breastfed until the child went to sleep or did not want any more. Some mothers breastfed six or seven times during the day, but not at night, and said they sometimes used sleeping medicine to make sure their babies slept until morning. A few Uzbek mothers said they coaxed their babies to feed and if the babies seemed agitated would make happy sounds, lie down next to them, kiss them, and try to get them to breastfeed. A few mentioned continuing to breastfeed when a child was ill.

When asked about what they thought affected the amount of their milk, a few mothers who had produced less breast milk reported that they noticed an increase in the amount of their breast milk once they started breastfeeding many times a day. One Uzbek mother in Qaramqul said, *“My milk [quantity] is good now. I used to give other [powdered or animal] milk to my other children because my milk was not so much. But now I don’t give other milk. Every time when the child gets hungry, I give my own milk. The more I give, the more my breasts fill up with milk.”*

#### **5. Most mothers linked their own diet to the quantity and quality of their breast milk and also to child health.**

*I did not breastfeed for three days because I wanted to remove filla from my breasts. But I also didn’t have much milk. I was hungry and we did not have anything to eat. I begged for flour. After I made bread and ate, my milk came.*

An Uzbek woman, Andkhoy

*If I eat a lot, my milk increases and I give one breast to one of them [twins] and the other breast to the other. My husband brought half a kilo of meat and I ate shorba four times that day. If I eat a lot, my milk increases; if not, it gets less. Sometimes, if I don’t eat and I give milk to both of my twins my eyes get dark and I feel weak.*

A mother of twins, Andkhoy

*I eat food a lot to increase my milk. I am a mother, and I have to give milk to my baby. My family says that I should eat a lot and whenever I feel hungry I should eat. Whenever I eat, I also drink*

*liquid. This increases my milk. I eat hot food such as akta (a special porridge for breastfeeding mothers made with whole wheat grains, flour, and sugar), peyawa (a special soup for breastfeeding mothers with beans, lentils, rice, and often meat), and egg after delivery, and after some weeks, I eat soft mutton. I don't eat cold food, cold water, aash (a special soup made with pasta, beans, chickpeas).*

An Uzbek mother, Andkhoy

*My milk was good when I had my first child. I don't know why it gradually got less. It is less with this child [a girl]. I go to weave carpets and earn some money. I'm always thinking about what we will eat today and what we'll eat tomorrow—with these worries, my milk decreased. Our life goes on only with my gharebi (labor).*

A Turkmen mother, Andkhoy

Most respondent mothers felt their own diets were related to the quantity and quality of their breast milk and to the health of their children. Most mothers reported that if they ate more food, at the prescribed three times a day, they would have more breast milk. Some mothers complained that they did not have enough breast milk, mainly because they were poor and could not eat enough food, or ate only bread and tea. Most mothers said they had learned about the importance of their own nutrition from clinic staff. Husbands and mothers-in-law encourage mothers to eat more to help breastfeeding.

Beliefs about the effects of “hot” and “cold” foods influenced what breastfeeding mothers ate, although researchers found beliefs and practice varied. In the first day or two after delivery, some mothers ate “hot” foods to encourage the flow of breast milk, to clean their wombs by stimulating vaginal discharge, and to cure post-partum fevers and shivers. They then began to consume more “cold” foods to keep the flow of breastmilk good, but maintained a mix of hot and cold foods. During the *chilla* period, most mothers followed a restricted diet with no eggs or meat (thought to cause diarrhea and stomach ache in the breastfeeding newborn). They drank tea in huge quantities, but avoided water because they thought it would cause infection in the womb and swelling of the stomach (*gazak*). This belief about water causing infection of womb was also reinforced by some traditional birth attendants and, in some cases, by clinic staff. This restricted diet may affect the health of mothers at a time when they are breastfeeding as well as recovering from the stress of the delivery.

Most lactating mothers continued to follow a regulated diet to promote children's health and prevent illness. Mothers felt that eating too much cold food could lead to a reduction in breast milk production, give a child “green diarrhea,” and/or cause the child's chest to catch cold, potentially causing acute respiratory infection. Too much hot food could lead the child to develop diarrhea, stomachache, gas, pimples, or rash. Those who could afford it ate soft rice, soups, lamb, and a lot of oily food. Many lactating mothers also ate *jawaanee baadiyaan*, an herbal seed usually mixed with aniseed to prevent breast milk from becoming gaseous. Some women thought that their eating watermelon and *pulao* (a rice dish) would cause diarrhea in their babies. Some fathers mentioned giving their wives camel meat to increase breast milk production.

### Examples of Cold and Hot Foods

Cold foods	Medium foods	Hot foods
Rock sugar ( <i>nabat/qand</i> ) Sugar ( <i>shakaar</i> ) Almonds ( <i>badaam</i> ) Raisins/currants ( <i>kishmish</i> ) Watermelon ( <i>tarbooz</i> ) Onion Some types of lentils Some pasta dishes ( <i>aash</i> ) Rice Broth Sunflower ( <i>pakistani</i> ) oil	Lamb/mutton	Pumpkin, melon ( <i>kharbooza</i> ) Beans ( <i>lubia</i> ), lentils ( <i>mash</i> ) Eggs (also thought to worsen jaundice in newborns) Sesame ( <i>kunjed</i> ) oil Some pasta dishes ( <i>aash</i> ) Walnuts ( <i>charmaghz</i> ) Camel meat, beef, chicken Soup with meat Fat (e.g., <i>roghan-e zard</i> ), butter <i>Pulao</i> , <i>Laiti</i> (a porridge) <i>Akta</i> , <i>Peyawa</i>

### 6. Some families linked mothers' health to the quantity of breast milk.

*Thank God that I have milk—whatever I eat turns into milk. If I worry, my milk gets less. A few months ago, my 12-year-old son fell into a pond and drowned. Because of this, I worry a lot. That's why my milk is less.*

An Uzbek mother, Andkhoy

*I have enough milk—it even falls out of the baby's mouth. But it was more with my other children—I don't know why it's less now. Maybe it's because of my weakness or maybe it's because one of my breasts is small and has slowed down.*

An Uzbek mother, Andkhoy

Many mothers who had more than three children complained of weakness and reduced breast milk, and mentioned that with every child their milk quantity became less. Many also said that when they were sick they would follow a restricted diet that would decrease their breast milk. A few complained that their breasts had dried up. A few mothers mentioned that depression and worry reduced their breast milk. Some fathers mentioned that their wives were weak and ill and therefore produced less breast milk.

### 7. Some families said that supernatural powers affect breastfeeding.

While a few mothers felt that their low breast milk production was God's will, some believed that jealous women cast the evil eye (*saya* or *nazar*) on lactating mothers, who therefore produced less milk. Some also believed that *nazar* could make children stop breastfeeding. Several nursing mothers and their husbands said they regularly got prayers and amulets (*taweez*) from *mullahs* to cast away the evil eye.

### 8. "Real" weaning starts when the infant is five or six months old; most weaning diets include high-carbohydrate, low-protein foods and foods of little nutritional value.

*We give the child food that we ourselves eat. Anytime the child wants [it], we give him food because a hungry child is more powerful than a king. The child makes us accept anything he wants.*

A Turkman father, Andkhoy

*They [health clinic staff] show a cloth [flipchart for health education] in the hospital and they teach us. I don't know what they say, but they show Afghan women making food for children. We are not that kind of women, and we don't make special food [for babies].*

A Turkman woman, Andkhoy

*I didn't give my older children solid food to wean them off—they started eating themselves. I thought if I gave them food their stomachs would get big. Now, they tell me in the clinic that I must given my son food after six months. My other children are thin because I didn't give them food. Now I know that food is good for children and keeps them healthy.*

A Turkmen mother, Khancharbagh

*I put some yogurt on a plate and add pieces of bread. I also give peyawa, shola, shorba, and soft food, cream, and shir berenj (a sweet dish made with rice, sugar, and milk). I don't give pulao or meat as they are hard foods and upset a child's digestion. His grandmother helps me—we feed with hands and sometimes with spoons.*

A Turkmen mother, Khancharbagh

*We start giving food when a child is a year old. We give them foods like tea, water, biscuit, grapes, melon, watermelon, and powered milk (shir podai). We give potatoes, soup, and shola (rice porridge). I chew mutton well and give it to my child. We start after a year so the child will grow healthy. Usually mothers and grandmothers decide what to feed them. We also give bread, cow's milk, and nabat. Whenever the child feels like eating, the mother feeds him or her in a separate plate.*

A Turkmen father, Andkhoy

Most respondents mentioned that their children received real complementary food, including family food, when they were five to six months old. (By interviewees' definition, real food does not include the soft food that most babies less than four months receive.) Children are then *dastak cha*—able to eat. Mothers continued to provide milk (breast, powdered, or animal) during this period. Many mentioned that they started weaning at five to six months on the advice of health clinic staff. A few mentioned that food should be introduced as early as three to four months after delivery, while a few mentioned waiting until a child was as many as 16 months old. Those families who delayed introduction to complementary foods (past five or six months) waited until a child demanded food itself or moved towards food.

When mothers weaned their children, they continued to provide milk: either breast milk, if they were breastfeeding before, or powdered or animal milk. A few fathers believed that children who got enough breast milk didn't move toward food. In addition to the times a mother breastfed her child, most families fed their weaning child three times a day (usually when the family ate) and also gave the child biscuits or bread at other times of the day if the child indicated that s/he was hungry by crying or by moving towards food. Some parents indicated that, in addition to drinking breast milk, weaning children should be fed three to four times a day in summer and twice a day in winter.

A few mothers and their mothers-in-law decided when to start weaning the child, and started weaning when they thought their milk is not enough. As one Turkmen mother from Khancharbagh explained, “She was four months old when I gave food because my milk was not enough.” Some fathers also had an influence; according to one Uzbek mother from Andkhoy, “After six months I gave food like soup, rice, and cereal. Her father said to give it quickly so that she can grow up.”

Respondents fed their children family food, sometimes made soft for them. This is mostly because they did not have the time to prepare special foods, and they did not see it as necessary. As one Turkmen mother from Andkhoy explained, “*We don’t cook any special food for them; we are not unemployed!*”

A few families with cows started giving children buttermilk (*chaka*) at three months. Most families fed four-to-six month old children *shola*, *luhab-e berenj*, soup, and *kitcheri* three to four times a day. Older children are fed *pulao*, *shola*, soup, soft rice, biscuits soaked in tea, *shorba*, *firni*, yogurt, and potatoes. Some families said they fed children camel’s meat, and a few fathers said beans provided babies with energy.

As in the case of lactating mothers’ diets, beliefs about food and its effects were varied. Turkmen respondents identified potato, camel meat, *shola*, and soup as good for weaning children. Beliefs about foods had to do with hot and cold effects and with digestibility; in general, eggs and meat were avoided because of their “hot,” “hard,” and/or “strong” effects. Some respondents indicated that they did not feed their weaning children “hot” foods in the summer, or “cold” ones in the winter. The table below shows some beliefs expressed about the negative effects of certain foods on weaning children.

<b>Foods</b>	<b>Their negative effects</b>
<i>Kichri</i> , <i>nask</i> (not identified) (Turkmen)	Hard for babies to digest
Sugar (Turkmen)	Causes babies stomachs to distend
Meat, meat soup	Is oily, has “hot” effects
Egg	Has “hot” effects, can cause jaundice, can make a child deaf, “make a child’s age short”
Yogurt, biscuits soaked in cow’s milk, grapes	Have cold effects
<i>Halwa</i> , <i>aash</i> , rice, eggs, grapes, <i>aash khamir</i> (Uzbek)	Cause diarrhea
Eggs, beef, potato, water, tea	Make a child’s stomach weak
<i>Shir berenj</i>	Give a child a pot belly
Fish	Has a hot effect, causes gas
Tomato	Causes diarrhea

A few Turkmen parents referenced the preventive characteristics of some foods. They fed their children apples, watermelon, melon, and grapes to prevent jaundice, diarrhea, and other sicknesses.

Interviewers asked all in-depth interviewees what they had fed their children in the previous 24 hours. Mostly, mothers reported giving their children boiled water, sugary tea, melon and watermelon, soup, *kichri* (soupy rice with pulses), bread, rice, potatoes, yogurt, and animal or powdered milk, cookies and wheat biscuits. A few mothers reported having fed their children cooked okra, *qorma kachalu* (potato stew), grapes, pomegranates, and apples. The described diet is high in carbohydrates and low in protein, and may contribute to acute and chronic malnutrition within this age group.<sup>49</sup>

<sup>49</sup> These results are comparable to the WHO study, which found that babies were started too early on inappropriate foods such as non-human milk and biscuits, and when other food were introduced they were very poor in iron. Food rich in iron, such as meat, eggs and beans, were not used at all.

## **9. Feeding practices make food manageable for weaning children.**

Children being weaned generally ate with the family at mealtimes, and were given biscuits and bread at other times of day. While older children usually ate from their mother's (or sometimes grandmother's or father's) plates, food prepared for smaller babies was served on a separate plate. Family members said they made sure the food was soft, and broken into small pieces for the child. Some mothers reported chewing the food first before giving it to the child. Children were given food by hand, without using utensils (typical of normal eating methods). Although this is positive because it shows that the food is made into manageable portions for a child, it is possible that if family members do not practice good hygiene, dirty hands might cause illness. This research did not include specific questions or observations about hand washing or use of soap.

Many mothers talked about how their children left a lot of food, and did not eat enough. In a few cases, mothers tried to push their babies to eat. But mostly, feeding was not active, and mothers said that the child ate until s/he was no longer hungry.

## **10. Family members play important roles in women's and children's food consumption.**

*My husband says, "Because you give milk, eat more."*

An Uzbek woman, Andkhoy

Mothers-in-law played an important role in deciding what lactating mothers should eat, although their recommendations varied. Most encouraged the mother to eat more while she is breast feeding, and especially oily food. In many cases, husbands also took an interest in giving good food so that mothers could produce more breast milk.

Mothers, grandmothers, and older children normally helped mothers feed children. Sometimes, elderly grandfathers who were in the home helped to feed children, but fathers rarely fed their children. Usually, fathers bought raw ingredients from the market, and in a few cases fathers reported that they helped feed their children. A few fathers did not know what their children ate. They mentioned that it was the mother's role to decide what to give a child to eat. One Turkmen father from Qurghan said, *"The mother does everything (for the child). I don't take part. During a child's sickness, I discuss [with the mother]. Otherwise it is not my duty."* Mothers said they sought advice from their mothers-in-law, other elderly women in the neighborhood and, many, from health clinic staff about what to feed their children.

As many mothers wove carpets, family members also helped to look after children while mothers were working. A few mothers with less family support put their babies' cradles next to them and rocked the babies while they worked. (Note: a few start weaving carpets ten days after delivery.)

## **11. Many mothers continue to breastfeed when their child is sick and supplement the child's diet with soft or milky dishes.**

*Whenever the baby cries, I give milk; at night, too. When she was well I was giving milk. Now that she is sick, I am still giving her milk; I give more milk. I weave carpets, and whenever she cries, my mother-in-law calls me. I have enough milk, and I can feed her whenever she wants.*

A Turkmen woman, Andkhoy



*When the child gets sick, the mother breastfeeds and gives biscuit and watermelon. We also give soft foods like shola (soft lentils and rice mixture), soup, luab (mashed) shola, tea, and water. During the child's sickness, we make less food because eating is hard and the child's stomach can't digest. Mothers know what to feed. Sometimes we ask neighbors or get advice from clinic doctors. When the child gets better, we give food that gives energy like meat, pulao, shola, and eggs.*

An Uzbek father, Qurghan

*If a child has diarrhea or fever, we give medicine and ORS. We also give Fanta, watermelon juice, and boiled water. Watermelon is good as the child feels strong.*

A Turkmen mother, Khancharbagh

Families know that sick children need special feeding, including increased breastfeeding, and few continued to feed them normally. Only a few family members did not mention increasing breastfeeding when the child is sick. Although mothers reported trying to breastfeed their infants when they were sick, many reported that their sick infants did not drink much breast milk.

Most families gave soft food and boiled water to sick children, although a few mothers said that giving a sick child food could make its condition worse. Soft food includes soaked wheat, soaked biscuits, and soups. Families avoided giving food like rice or eggs, which they believed to be hard foods, because they believe the child would have difficulty digesting them. These families reported supplementing the sick child's diet with milky dishes like *halwa* (coarse ground wheat, sugar and oil) and *ferni* (a boiled-milk sweet dish), and with powdered milk, as well as increasing the child's intake of boiled water—all positive practices reinforced by health education messages at local clinics. Families also believed that sick children experienced loss of appetite, and so they said they tried to coax them into eating by clapping their hands, or talking to them. A few mothers prepared more food than usual when the child was recovering from an illness. It was also noted that some fathers took part in feeding sick children. A few mothers said they did not give sick children solid food as they believed it could make them sicker or kill them.

Many families mentioned giving their children oral rehydration solution (ORS) if they had diarrhea. A few fathers mentioned that mothers fed children sugar water (*nabat*) and chickpea soup when they had pneumonia (*sina baghal*) or cough (*surfa*), and watermelon juice when they had measles (*surkhakan*) or diarrhea (*ishal*).

While some families gave recovering children more food than usual, others fed according to the child's appetite. Families also reported giving their children vitamin-rich fruits to help them recover from illness, which is another positive practice; several respondents reported feeding recovering children fruits such as pomegranates, oranges and apples. Grapes were avoided because of the belief that they would make babies' stomachs distend.

## **12. Most mothers consult their husbands and mothers-in-law when their child is sick, and take the sick child to a clinic.**

Almost all families indicated that they went to the clinic if their child was ill, and most fathers gave permission to their wives to go to the clinic alone; this may relate to the fact that the health care infrastructure in the Andkhoy area is relatively well-developed and long-standing. Many respondents, especially fathers, reported taking their newborns to the doctor in the first few days after birth in order to get them vaccinated or checked by the doctor. And, when their children got sick, most mothers consulted with their husbands and mothers-in-law, and also with neighbor women and traditional birth attendants.

Most took their sick children to the health clinic. Some (also took their sick children to *mullahs* or religious healers. Those who went to the clinic reported giving their sick children the prescribed medicines. Aspirin or ORS were the identified medicines, but in some cases the medicine was unidentified.

### 13. Many families use home remedies or other traditional approaches on sick children.

*When my child became sick I took her to a unaani (homeopathic medicine) doctor. She greased the child's hands with Vicks™ to make the veins of the child's chest soft. The child became better. Another time I took my first child to this woman; she made some small cuts on the shoulder with a razor blade and took out the unclean blood. I myself don't have any special idea about this, but this is common in the village. They do this because there is a sickness called ifti (a disease which causes the blood of the child go bad), which, if not treated, can kill a child.*

An Uzbek father, Andkhoy

Many families used home remedies to treat sick children, and some sought the advice of neighbors, elderly women and *mullahs*. The research did not investigate the positive, neutral, or negative effects of these practices. Respondents identified a number of home remedies for small children, including:

- *For fever:* aspirin in *roghan-e zard* (fat/oil) or in breast milk fed to the child; eggs mixed with salt in a paste for the child's head; raw grape juice (*jal*), water, boiled rice, and salt in a paste for the child's entire body; boiled *reshqa* (grass) rubbed on the child's body or eaten in a *mantu* (dumpling); yogurt mixed with dust and rubbed on the child's head; *taq* plant<sup>50</sup> leaves or *shola* rubbed on the child's body to induce sweating; *taryaq/kooknar* (opium) rubbed on the child's neck.
- *For diarrhea:* egg yolk massaged on the child's nipples; yogurt mixed with *gul-e zard* (a yellow flower) fed to the child; boiled egg mixed with pomegranate peels fed to the child; a mixture of yogurt, *tak* leaves, and pumpkin leaves in a cloth buried in embers for five minutes, then mixed with pomegranate peel and fed to the child.
- *For abdominal pain/constipation:* gripe water, *khamir tursh* (fermented dough used as yeast) placed on the child's navel.
- *For pneumonia (sina baghal):* onions fried in oil fed to the child or rubbed on the child's body.
- *For cough:* boiled opium fed to the child.
- *To ease breathing/make the chest "soft":* menthol cream (*vicks*) massaged on the child's chest or hands, *khamir tursh* on the child's shoulders.
- *For a blocked nose:* a few drops of boiled opium in the child's nose; a drop of mother's milk in the child's nose.
- *For earache:* oil of fox mixed with water in the ear, dry tea leaves in the ear; two drops of *kunjed* oil in the ear; oil, in which an egg is fried burned and then discarded, dropped in the child's ear.
- *For headache:* *taryaq* (opium) rubbed on the neck.
- *For jaundice:* *khulfa* (a kind of wild grass) plucked in small pieces while praying and put in the sun.
- *For measles:* hot foods fed to the child to encourage the rash to come out; burn *asfan* (an herb) in the house; place knives under child's bed to frighten *jinns* (spirits) causing measles.
- *To encourage breastfeeding:* menthol cream (*Vicks*) massaged on the child's chest.
- *To increase appetite:* opium rubbed on the child's nose and forehead.
- *To encourage sleep:* *taryaq/kooknar*.
- *For "bad blood" or ifti* (a disease that causes the blood of the child go bad): traditional healers cut small wounds into the child to expel bad blood.

<sup>50</sup> The researchers were unable to identify the English translation for *tak*.

- *Against the evil eye*: *taweez* (amulets) from and prayer by *mullahs*; burn *zamch* (an herb used to preserve meat) and seven pinches of flour and rub on the child's hand; *khulfa* plucked in small pieces while praying and put in the sun.

#### 14. Use of opium seed and poppy seed to make babies sleep is common.

*If I didn't give taryaq, I wouldn't see day or night. I give taryaq once in the morning and once at night.*

An Uzbek woman, Qurghan

*No, I don't give taryaq (because it is bad for the child). The neighbors gave taryaq and now the child's nervous system is bad.*

A Turkmen woman, Andkhoy

In addition to rubbing *taryaq* on their children when they are sick, many mothers reported feeding their babies *taryaq* when they cry a lot or when parents wanted them to go to sleep. Interviewers also observed this practice during several qualitative consultations, and many fathers also reported this practice. One Uzbek woman from Andkhoy told us, “*Until the child is three years old, I give taryaq to him to go to sleep; otherwise I cannot work [make carpets].*” Only a few women knew that giving opium was harmful to children. One Uzbek woman from Qurghan said, “*I gave taryaq to my other children to go to sleep, but I don't give it to this child because they told me not to in the clinic.*”

The high use of opium and poppy seed for babies is a worrying finding because it can easily decrease their appetites, and can lead to harmful addiction. This finding appears to be unique to the Andkhoy area, and was not found in other areas where UNICEF and WHO did research. It is probably a consequence of mothers needing to work on weaving carpets for long hours in the day, and thus needing to keep their babies quiet.

#### 15. Knowledge and caregiving behaviors probably affected under-two nutrition more than the drought.

*Before the drought, our babies were fat and healthy, but when the drought came our babies could not eat properly and they became thin and weak.*

A Turkmen father, Khancharbagh

*There were changes in our food. Before [the drought] I would eat oily food. Since the drought started, nobody is buying carpets. Even if a carpet was sold, we got little money for it, which is not enough because our family is big.*

An Uzbek mother, Andkhoy

*Beans, oil and sugar were distributed recently [at the clinic] so the mothers' diets are good.*

Participant, focus group discussion

*When the clinic gave beans, we gave them to our child.*

An Uzbek father, Qaramqul

*Three years back it was really bad. It was hard for children and old people. Children needed food and their fathers and mothers couldn't prepare it for them. The children were used to bread, and where could we find it? We had only half a seer or one seer (7 kgs) of wheat that we bought from the bazaar twice a week. We cooked rice. Food was really expensive and men didn't have jobs. Compared to three years ago, it's good now—men have jobs and cultivation is good.*

A Turkmen mother, Arab Shah Paeen

*The past three years of khushksali (drought) shook the earth and sky. We sold our sheep and we sold our three cows and we also sold two camels. We then sold our cart. First of all we sold the donkey. I sold all my jewelry. We sold our two chickens. We sold everything to pass the difficult time. Now we are happy and our life is getting good because the akwan motahida (United Nations) helps us.*

Unknown source

The people of Andkhoy were affected by the drought in a number of ways although this previously prosperous area seems to have had enough resources to avoid large scale acute malnutrition and permanent economic damage. Most respondents talked about the drought in the last three to four years, and how they were worse off during these years. Many Andkhoy area families sold their furnishings, rugs, jewelry, and other household items as well as their livestock to get money for food, or borrowed it. Because they had less income, they could not buy as many medicines either. People suffered not only from the loss of crop cultivation and sale of livestock<sup>51</sup> and household items, but also from a slowdown in the local carpet economy on which many of them depend. Some migrated to Pakistan, where they sold carpets because the carpet market collapsed in Andkhoy. A few Turkmen mothers mentioned that their farmer husbands started to work as soldiers. A few Turkmen fathers mentioned that they had always been poor, but drought made life even more difficult for them because they could find no work. Only very few better-off people were not affected by the drought, and they gave charity (*zakat*) to help the poorest people.

Respondents indicated that the drought and its follow-on effects did affect diet in the area. Mothers reported not being able to give their children fresh milk, butter, or yogurt, and a few Turkmen mothers said that their most recent child was thinner and weaker than earlier children because they weren't able to eat good quality food such as *aash kamir*, *kitchri*, *shakaar* (sugar), soup, *nabat*, and *roghan-e zard*. They started mixing potato with bran and used it as bread; some fathers reported their families began to eat corn (*jawari*) and millet (*arzan*), which are viewed as poverty foods. Some middle class people reported that during the drought they could not eat meat or oily foods for several days at a time because they could no longer afford them. According to one mother, “*We sold our cow and sheep because there was no grass. The children didn't have meat or milk for three years.*”

Many respondents reported that nursing mothers' milk was less during the drought, mainly because mothers had less to eat. Most respondents also talked about not having enough food for their children, especially fruit and other varieties of food. A few mentioned that a lot of children had died during the drought, but no confirmation of these assertions was available. Although the research did not specifically address this, SC/US staff feel that the drought in the Andkhoy area did affect access to water and the quality of water (it was much more saline than normal). This may have had an effect on hygiene practices

---

<sup>51</sup> The availability of livestock products was heavily affected by the drought when people sold their livestock because they could not feed or water them, or because they needed money. Clearly, the sale of livestock has a more long-term effect than the lack or loss of agriculture because it takes far more time to rebuild livestock-related capacity than to replant crops.

and the subsequent increased risk for disease in children, contributing to the cycle of disease and malnutrition.

However, it is possible that the drought did not have a particularly negative impact on children under two. All FGD and IDI respondents were assisted during the drought years by SC/US food distributions (especially those targeting pregnant women and lactating mothers); the food distributed to pregnant women and lactating mothers included oil, beans, sugar, and iodized salt. Many respondents, both female and male, talked about the help of international organizations in providing food for work projects, and in providing complementary food items for mothers and children. Some families said that they had sold this food to buy other necessary items, others that they and their children had eaten it and that it was very helpful.

Even though this research was conducted during the first *non*-drought year, food variety was still limited for children during the weaning period. It may be that malnutrition is related more to general child feeding practices, rather than to the drought and general food security issues. Families do not have the knowledge that protein is important for the child, or what the important sources of protein are.

All agreed that the situation had improved in 2002, when the rains came. Several did say they were still suffering from the effects of the drought because they had sold their livestock or seed, and therefore could not cultivate the land.

## **Conclusions & Recommendations**

This qualitative study sought to provide a better understanding of the determinants of nutritional status of children under the age of two years in the Andkhoy area, focusing separately on breastfeeding and weaning practices for (1) infants under four months and (2) those between four months and two years of age. This study is one of three studies conducted in Afghanistan in recent years that focuses on child feeding issues; the other studies included a 2002 study conducted by WHO in IDP populations in Kunduz; and a 2003 UNICEF/MoH study in the Panjshir.

The results of the three studies are similar, despite their having been conducted using somewhat different tools and methodologies (the SC/US and UNICEF studies had some overlap) and among very different communities in different areas of Afghanistan. This indicates that the general trends on practices related to breastfeeding and weaning Afghan infants are known. Given that malnutrition, especially in young children, is an issue of public health concern in Afghanistan, there is an ethical responsibility to use this data and information to develop programmatic interventions that address the key issues raised by the three studies.

The Andkhoy MoH and SC/US are using the standard MoH/UNICEF breastfeeding research flipchart to conduct health education in the seven-year-old Andkhoy area Primary Health Care (PHC) program. The results of this research show that the health education within the Andkhoy PHC program has had many positive effects, including: such as generally good health-seeking behavior and feeding practices when the child is sick; introduction of weaning/complementary foods between the age five and six months; use of colostrum by just over half of families; and family knowledge that breastfeeding is good for children and should be continued for two years.

However, the research has also brought to light important nuances of breastfeeding and weaning beliefs and practices at the family and clinic levels in the Andkhoy area that were not previously understood in detail. For example:

- clinic practice may encourage families to give pharmaceutical glucose to their newborns;
- health education messages about exclusive breastfeeding have not made clear that this means no water at all, even in the hot summer months, except when the child has diarrhea and when ORS is needed;
- health education has not emphasized the *types* of complementary foods that should be given during weaning;<sup>52</sup>
- community health workers have not been trained how to counsel mothers on appropriate breastfeeding practices; and
- important hygiene messages about hand-washing before feeding children have not been emphasized.

Although further research may achieve greater understanding in specific areas, it is perhaps more important to work quickly on the findings now available. These findings lead to a number of recommendations for improving breastfeeding, weaning, and feeding information in support of young children's health:

### **1. Develop health education/counseling messages about breastfeeding and weaning that take better-understood beliefs and practices into account.**

Health education material using these messages should be developed on a national level using the findings of the three studies to help conceptualize and articulate key messages, and to tailor educational materials to target audiences, e.g., mothers-in-law and fathers as well as mothers. To advance this recommendation, SC/US suggests a series of national discussions involving the Ministry of Health, SC/US, UNICEF, WHO, and other organizations with experience in the field. Based on the findings of SC/US and other research, five key messages could address the following topics:

- Immediate breastfeeding, with colostrum
- Exclusive breastfeeding without the need for water or supplementary food
- Counseling on positioning the baby for effective breastfeeding
- Weaning at four to six months with nutritious, protein-rich complementary food
- Good hygiene for all family members feeding babies and young children

In preparation, there should be a collection and review of breastfeeding and weaning educational materials and messages currently used by organizations in Afghanistan. Following the development of standardized national health education material and suggested modes of effective and appropriate communication, there needs to be dissemination of this material to all appropriate government health facilities and personnel along with a plan for appropriate training to ensure that recipients of the material understand, accept, and can convey the messages.

During the analysis, investigators found little difference in responses between people of Uzbek and Turkmen ethnicity. Also, key practices found in this study are similar to those found by the WHO and UNICEF/MoH studies conducted in different areas of Afghanistan and researching communities of varied ethnicities. Thus ethnicity does not seem to be a major factor influencing breastfeeding and weaning

---

<sup>52</sup> For example, it would be interesting to look at cultural understandings about cold and hot foods, and hard and soft foods, and to think about messages that emphasize nutrition.

practices. This may make it easier to develop health education material at a national level for Afghanistan.

## **2. Target messages broadly—at mothers, other family members, and influential community members.**

The findings of this research suggest that breastfeeding, weaning, and feeding messages should be targeted broadly. Messages about colostrum should be directed not only at mothers, but also at other influential women in the family (such as mothers-in-law and sisters), and fathers, all of whom were seen to have a major influence on the decision to give or discard colostrum. Women who reported being shy to breastfeed in front of others as the reason for their delay in immediate feeding were young or first-time mothers. When addressing the issue of immediate breastfeeding in programs, it is important to target mothers-in-law and other senior female members of the family, who are all normally present in the delivery room and help to look after the newborn. They can then help to influence the young mother positively, and encourage her to breastfeed the infant immediately.

Messages on feeding should target all family members, since many are involved in feeding the child – especially older siblings and mothers-in-law. In the Andkhoy area where many women weave carpets, these family members are also involved in helping to look after the child when the mother is busy working, and may have more contact with the young child than in other geographic areas. Fathers should also be targeted in health education messages about complementary food, because they buy food from the bazaar. Fathers should also be included in activities targeting danger signs for illnesses, since they are involved in the decision-making process of if and when to take the sick child to the doctor.

The MoH and UNICEF are already discussing including breastfeeding, weaning and related topics as part of the Community Health Worker (CHW) training curriculum, after which CHWs would do home-to-home visiting with women where possible. Other suggestions have included addressing the issues of breastfeeding and weaning through health education, individual breastfeeding counseling, awareness-raising among pharmacists about problems associated with bottle-feeding instead of breastfeeding, engaging *mullahs* and other influential community members as advocates, and using radio spots.

## **3. Use local knowledge that supports positive practices in messages and other outreach.**

Messages may be more effective if they are tailored toward common, well-understood analogies – for example, by saying that colostrum is the first vaccination for the child or by reminding families that farmers know that the cow's first milk is best for the calf. Reminding people of positive messages in the Qu'ran is also a good strategy. For example, health care workers can build on the positive common belief that children should be breastfed for two years<sup>53</sup> to promote birth spacing, which is beneficial for children and their mothers. They can also incorporate families' knowledge about the importance of mother's diet and terms used for different foods within the existing birth planning/preparedness health education and counseling messages.

A potentially powerful strategy for building on positive local knowledge is the positive deviance model. The positive deviance model is used to identify a beneficial practice within the community, and then propagate this practice to others in the community by showing, first, why and how it is beneficial, and then that it is locally feasible and acceptable. The experiences of women who do give their newborns colostrum can be incorporated within the existing health

---

<sup>53</sup> According to one Islamic teaching.

education messages and activities and used as examples for other families. The fact that approximately half the women interviewed did give colostrum to their newborns shows that there are role models who might help change colostrum-giving behavior in these communities.

#### **4. Challenge/correct misconceptions about immediate and exclusive breastfeeding and about weaning foods and offer ways to improve diet diversity.**

This study found that respondents held a number of misconceptions about, or have different ways of understanding, diet and nutrition that have implications for children's nutritional status. For example, the fact that just under half of the respondents said they discarded colostrum because they felt it was unhealthy indicates that substantial work must be done to correct this view. The study also found a general misunderstanding as to what giving *only* breast milk means and beliefs about the need for extra water, glucose, or soft foods for newborns need to be addressed.

The findings also suggested that many families do not feel that weaning age children need special food, nor do many feel they have time to make them, and the weaning foods families deem most appropriate for their children may not be those that are most nutritious for them and perhaps perceptions of soft and hard foods need to be balanced with information about their nutritive value and suggestions about appropriate, quick, and inexpensive weaning food possibilities. Providing information about diet diversity and children's (and adult's) nutrition needs may not be enough in some contexts, and assistance actors will need to consider ways to encourage and facilitate conditions for diverse and healthy diets.

#### **5. SC/US and the MoH should work together to address Andkhoy-specific issues.**

One important issue specific to Andkhoy that was confirmed by this research is that of providing opiates to children when they are ill or to make them sleep. Messages should discourage the use of *taryaq* when the child is well or sick.

The research also helped look at different home remedies for sick children, which can be classified as harmful or neutral. While there is a need to identify and discourage the harmful practices and ignore the neutral ones, more exploration is needed to identify helpful practices, especially for the sick child management at home. Caretaker counseling that supports and praises the family's helpful practices can help discourage the harmful ones.



**Appendix 1: Malnutrition and stunting rates in North Afghanistan, SC/US nutrition surveys 2002**

	GAM Children 0-5 months	GAM children 6-29 months	GAM children 30- 59 months	SAM children 0-5 months	SAM children 6-29 months	SAM children 30- 59 months	Global stunting rate 0-59 months	Severe stunting rate 0-59 months
Andkhoy area (Faryab Province)	3.8% CI <sup>54</sup> : 1.2–8.8%	18.5% CI: 12.6–24.4%	3.2% CI: 1.7–4.7%	0%	4.0% CI: 1.3–6.8%	0.4% CI: 0.1–0.9%	47.4% CI: 44.1–0.8%	22.6% CI: 19.9–25.5%
Kohistan (Faryab Province)	5.7% CI: 1.5–12.9%	17.1% CI: 11.9–22.3%	4.2% CI: 1.5–7.0%	0%	4.6% CI: 2.2–7.0%	1.1% CI: 0.2–2.1%	53.4% CI: 49.0–57.8%	28.5% CI: 24.8–32.7%
Belcheragh (Faryab Province)	1.4% CI: -1.3–4.1%	7.6% CI: 4.9–10.2%	1.2% CI: 0.2–2.3%	0%	2.3% CI: 0.8–3.9%	0.8% CI: 0.1–1.6%	60.5% CI: 56.1–64.7%	31.6% CI: 27.7–35.8%
Kohistanat (Saripul Province)	9.3% CI: 1.6–16.9%	9.8% CI: 5.2–14.5%	4.3% CI: 2.2–6.0%	0%	1.5% CI: 0.1–2.9%	0.4% CI: 0.1–0.9%	51.6% CI: 46.8–56.5%	25.8% CI: 21.8–30.3%

<sup>54</sup> Confidence interval.

## Appendix 2: Qualitative research tools

### Focus Group Discussion:

With mothers of children aged up to 2 years, fathers of children aged up to 2 years  
and with grandmothers

#### Introduction

*Hello. My name is \_\_\_\_\_, and I am working with Save the Children. We want to learn about breastfeeding practices and would appreciate your participation. This discussion usually takes 1 hour to complete. We do not need to know your names and will keep information strictly confidential and will not be shown to other persons. Participation in this discussion is voluntary and you can choose not to answer any questions. What we learn from you will help us and other health agencies to plan health messages for communities similar like yours.*

At this time, do you want to ask me anything about this discussion?

Name of the village: \_\_\_\_\_

Name of the District: \_\_\_\_\_

Predominant ethnic group:

Language:

Number of participants:

#### A. Immediate breastfeeding

*First, I am going to talk to you about the period immediately after the baby is born.*

1. In the first 3 days after babies are born, what do they eat?
  - *Probe for water, tea.*
  - *If they don't raise the issue, ask if they give colostrum*
2. Is colostrum good or bad for the baby?
  - *Why? Probe for myths.*
  - *Who says so?*
  - *If they don't give colostrum, what do they do with it?*

## **B. Exclusive breastfeeding**

*Now, I am going to ask you about the first 4 months of the baby's life ONLY.*

3. What do babies eat in the first 4 months after they are born?
  - *Probe for water, tea*
  - *Probe for powdered milk, and by bottle?*
  - *Probe for animal milk, and by bottle?*
  - *Probe for other foods*
4. Why are some babies given other food in the first 4 months?
  - *Probe for mother not having enough milk*
  - *Probe for perceptions on advantages / disadvantages of breast-milk*
  - *Who decides that a baby requires other foods/fluids in addition to breast milk?*
5. Has anything changed in the past few years?
  - *Probe for drought effect*
6. Do all mothers have enough milk to breastfeed in the first 4 months?
  - *Probe for drought reasons*
  - *Probe for poor eating / drinking habits of mothers*
7. For how much time should a mother feed her baby breast milk and nothing else?
  - *Why?*
8. Do you know the term “exclusive breastfeeding”?
  - *Is this term common?*
  - *What is the tradition around this term?*
9. When a mother is breastfeeding, does she eat the same amount of food?
  - *Why, why not?*
  - *Does she avoid any food? Why?*
10. When a mother is breastfeeding, does she drink the same amount of tea/water?
  - *Why, why not?*

## **C. Introduction to weaning/complementary foods**

*Now I am going to talk to you about when the child is older.*

11. How long should a mother continue breastfeeding her baby?
12. When (at what month) do mothers start giving the baby other food in addition to breastfeeding?
  - *Who decides when this time starts?*
  - *Why do they decide to start giving other food?*
13. What type of other food is given to the baby? (local terms)
  - *Probe for tea, water, non-human milk, powdered milk*
  - *Probe for meat, pulses, eggs, BP5 biscuits, biscuits, rice, yogurt.*
    - *What type of foods are good and why?*
    - *What types are not good and why?*
14. When a baby is given other food, how many times a day is he/she given this food?

15. Who feeds the baby?  
- *Probe for grandmother, younger daughter*
16. How is the child fed this food?  
- *Probe for bottle use, hands, plate, spoon*
17. Are babies ever given the food that is normally prepared for the family?  
- *When does this happen?*  
- *What food are they given?*  
- *Who decides to give them this food?*  
- *How are they fed (e.g. taste from an adult's plate)?*
18. Has feeding the child changed in the past few years?  
- *What has changed?*  
- *Why has it changed? (probe for drought)*

#### **D. Feeding during sickness**

19. When a child is sick, what is he/she given to eat?  
- *Probe for continuing / stopping breastfeeding, and why.*  
- *Probe for which other food he/she is given*  
- *Probe for if the child is given water*
20. When a child is sick, is he/she given more, less, or the same amount of food?
21. Who decides how and what to feed to a baby when he/she is ill?
22. Who else's advice is sought on feeding?  
- *Probe for health worker*
23. When a child is getting better from an illness, what is he/she given to eat?

#### **E. The effect of drought**

24. Has there been any changes in the way you feed your children over the past few years?  
- *Why – drought?*  
- *What kind of changes?*  
- *Since when?*

**In-depth Individual Interviews**  
**Mothers with babies 4 months or less**

*Introduction*

***Hello. My name is \_\_\_\_\_, and I am working with Save the Children. We want to learn about breastfeeding practices and would appreciate your participation. This discussion usually takes 45 minutes to complete. We do not need to know your names and will keep information strictly confidential and will not be shown to other persons. Participation in this discussion is voluntary and you can choose not to answer any questions. What we learn from you will help us and other health agencies to plan health messages for communities similar like yours.***

At this time, do you want to ask me anything about this discussion?

Name of the village:	Name of the District:	Ethnic group:
Language:	Age of the mother:	Literacy:
Age of the child:	# of children:	Economic status:

**A. Immediate breastfeeding**

1. Are you breastfeeding your baby now?
  - *Why, why not?*
2. How soon after the birth (number of hours or days) did you start breastfeeding?
3. If breastfeeding was delayed by more than 2 hours after birth, why was it delayed?
  - *Because of colostrum being bad? What does she do with colostrum?*
  - *Because of an illness? What illness?*
  - *Because of a tradition? Which tradition?*
  - *Other reasons?*
4. Who decided when you started breastfeeding?
  - *Probe for mother-in-law, dai, friends, tradition*
  - *What did they advise you?*
5. What is colostrum?
  - *Is it good or bad for the baby? Why? Record myths*

## **B. Exclusive breastfeeding**

6. Until now, has your baby had anything else to eat besides breast-milk? What?

- *Probe for water, tea*
- *Probe for powdered milk, and by bottle?*
- *Probe for animal milk, and by bottle?*
- *Probe for other foods*

7. Since this time yesterday, what have you fed your baby?

- *Record times of breastfeeding*
- *Record everything else that was given in addition to breast-milk*

8. What kind of water do you give your baby?

- *Probe for boiled water?*
- *How often?*
- *Why?*
- *With a bottle, or another method?*

9. Do you give your baby other milk (like animal milk or powdered milk)?

- *Why?*
- *How often?*
- *By what method?*

10. Do you know the term “exclusive breastfeeding”?

- *Is this term common?*
- *What is the tradition around this term?*

11. What are the advantages and disadvantages of breast-milk?

12. For how long will you continue breast-feeding your child?

13. When will you start giving your child other food?

## **C. Breastfeeding issues**

14. Do you have enough milk to feed your baby?

- *Why, why not?*

15. Was this the same or different for your other children?

- *Probe for drought, and whether her milk production has increased / decreased over the past few years*

16. How often do you breastfeed your baby?

- *During the day? During the night?*
- *Do you breastfeed on demand (when baby cries)?*
- *If the mother breastfeed on set times, find out number of times and reasons for doing this*
- *If the mother breastfeed less frequently, find out why? (e.g. heavy involvement in daily house-chores or shy to breastfeed in front of others or tradition or any other reason)*
- *If the mother breastfeed on set times/less frequently, how do they respond when a baby cries (let others take care, immediately breastfeed, give a pacifier, or opium to sleep, etc)*

17. Each time you breastfeed, how long does the baby stay at your breast?
18. Each time you breastfeed, do you switch the baby from one breast to the other?
  - *Why, why not?*
19. Now that you are breastfeeding, do you eat the same, less, or more food?
  - *Why?*
20. Are you eating the same food?
  - *If not, which foods are you eating and not eating? (e.g. myths of hot / cold food)*
21. How often do you have tea or water?
22. Who decides what you should eat or drink?
23. When do you breastfeed your child during your daily routine?
  - *Use the daily activity chart*
24. Does anyone else help you feed the baby?
  - *Probe for mother-in-law, other children, friends*

#### **D. Feeding during sickness**

25. If your child gets sick, what is he/she given to eat?
  - *Probe for continuing / stopping breastfeeding, and why.*
  - *Probe for which other food he/she is given*
  - *Probe for if the child is given water*
26. When a child is sick, is he/she given more, less, or the same amount of food?
27. Who decides how and what to feed to a baby when he/she is ill?
28. Who else's advice is sought on feeding?
  - *Probe for health worker*
29. When a child is getting better from an illness, what is he/she given to eat?

#### **E. The effect of drought**

30. Has there been any changes in the way you feed your children over the past few years?
  - *Why – drought?*
  - *What kind of changes?*
  - *Since when?*

**In-depth Individual Interview**  
**Mother with children under 2 years**

*Introduction*

***Hello. My name is \_\_\_\_\_, and I am working with Save the Children. We want to learn about breastfeeding practices and would appreciate your participation. This discussion usually takes 45 minutes to complete. We do not need to know your names and will keep information strictly confidential and will not be shown to other persons. Participation in this discussion is voluntary and you can choose not to answer any questions. What we learn from you will help us and other health agencies to plan health messages for communities similar like yours.***

At this time, do you want to ask me anything about this discussion?

Name of the village:	Name of the District:	Ethnic group:
Language:	Age of the mother:	Literacy:
Age of the child:	# of children:	Economic status:

**A. Introduction to weaning/complementary foods.**

1. Are you breastfeeding your baby now?
  - Why, why not?
2. How long should a mother continue breastfeeding her baby for (months, years)?
3. Are you giving your child any food or fluids other than breast milk?
4. When (at what month) did you start giving the baby other food in addition to breastfeeding?
  - Who decides when this time starts?
  - Why do they decide to start giving other food?
5. What type of other food do you give your baby? (local terms)
  - Probe for tea, water, non-human milk, powdered milk
  - Probe for meat, pulses, eggs, BP5 biscuits, biscuits, rice, yogurt.
  - What type of foods are good and why?
  - What types are not good and why?
6. Since this time yesterday, what have you fed your child?
  - Record times of breastfeeding
  - Record everything else that was given in addition to breast-milk



7. Are babies ever given the food that is normally prepared for the family?
  - *When does this happen?*
  - *What food are they given?*
  - *Who decides to give them this food?*
  - *How are they fed (e.g. taste from an adult's plate)?*
  - *Is this food made softer?*
8. When you give the baby other food, how many times a day is he/she given this food?
9. About how many days a week do you give your child food/fluids (other than breast-milk)?
10. Who feeds the baby this other food?
  - *Probe for grandmother, younger daughter*
11. How is the child fed this food?
  - *Probe for bottle use, hands, plate, spoon*
12. About how long does it take to feed your child each meal?
13. How does your child let you know he/she is hungry?
14. If the child refuses to eat what do you do?
15. Does the child always finish his/her food?
  - *If not, what do you do?*
16. Do you face problems feeding your baby?
  - *What are they?*
  - *How do you solve them?*
  - *Who else helps you? How?*
17. Has feeding the child changed in the past few years?
  - *What has changed?*
  - *Why has it changed? (probe for drought)*

#### **D. Feeding during sickness**

18. Has your child been sick since he/she was born?
19. When your child was sick, what was he/she given to eat?
  - *Probe for continuing / stopping breastfeeding, and why.*
  - *Probe for which other food he/she is given*
  - *Probe for if the child is given water*
20. When a child is sick, is he/she given more, less, or the same amount of food?
21. Who decides how and what to feed to a baby when he/she is ill?
22. Who else's advice is sought on feeding?
  - *Probe for health worker*

23. When a child is getting better from an illness, what is he/she given to eat?

**E. The effect of drought**

24. Has there been any changes in the way you feed your children over the past few years?

- *Why – drought?*
- *What kind of changes?*
- *Since when?*

**In-depth Individual Interview**  
**Fathers with children under 2 years**

*Introduction*

***Hello. My name is \_\_\_\_\_, and I am working with Save the Children. We want to learn about children's feeding practices and would appreciate your participation. This discussion usually takes 30 minutes to complete. We do not need to know your names and will keep information strictly confidential and will not be shown to other persons. Participation in this discussion is voluntary and you can choose not to answer any questions. What we learn from you will help us and other health agencies to plan health messages for communities similar like yours.***

At this time, do you want to ask me anything about this discussion?

Name of the village:	Name of the District:	Ethnic group:
Language:	Age of the father:	Literacy:
Age of the child:	# of children:	Economic status:

**A. Introduction to weaning/complementary foods**

1. Is your wife breastfeeding your baby now?
  - *Why, why not?*
2. How long should a mother continue breastfeeding her baby for (months, years)?
3. Are you giving your child any food or fluids other than breast milk/
4. When (at what month) did you start giving the baby other food in addition to breastfeeding?
  - *Who decides when this time starts?*
  - *Why do they decide to start giving other food?*
5. What type of other food do you give your baby? (local terms)
  - *Probe for tea, water, non-human milk, powdered milk*
  - *Probe for meat, pulses, eggs, BP5 biscuits, biscuits, rice, yogurt.*
  - *What type of foods are good and why?*
  - *What types are not good and why?*
6. Are babies ever given the food that is normally prepared for the family?
  - *When does this happen?*
  - *What food are they given?*
  - *Who decides to give them this food?*
  - *How are they fed (e.g. taste from an adult's plate)?*
  - *Is this food made softer?*
7. When you give the baby other food, how many times a day is he/she given this food?

8. Who feeds the baby this other food?
  - *Probe for grandmother, younger daughter*
9. How is the child fed this food?
  - *Probe for bottle use, hands, plate, spoon*
10. How does your child let you know he/she is hungry?
11. If the child refuses to eat what do you do?
12. Has feeding the child changed in the past few years?
  - *What has changed?*
  - *Why has it changed? (probe for drought)*
13. How do you, as a father, support your child's feeding?
  - *Buying the food?*
  - *Deciding which food?*
  - *Taking part in feeding?*
  - *Advising the mother / caretaker?*

#### **B. Feeding during sickness**

14. Has your child been sick since he/she was born?
15. When your child was sick, what was he/she given to eat?
  - *Probe for continuing / stopping breastfeeding, and why.*
  - *Probe for which other food he/she is given*
  - *Probe for if the child is given water*
16. When a child is sick, is he/she given more, less, or the same amount of food?
17. Who decides how and what to feed to a baby when he/she is ill?
18. Who else's advice is sought on feeding?
  - *Probe for health worker*
20. When a child is getting better from an illness, what is he/she given to eat?

#### **C. The effect of drought**

21. Have there been any changes in the way you feed your children over the past few years?
  - *Why – drought?*
  - *What kind of changes?*
  - *Since when?*

## OBSERVATION GUIDELINES

- Each household is visited twice during the survey (at random times)
- Ten households are visited each day (two visitors -> 5 households per surveyor per day).
- Observe and write in a separate sheet what you are observing during the 15 minutes.
- If you arrive when the child is being breastfeed or is eating semi-solids or solids foods, stay to record the whole feeding session.
- After the visit report on the format.

DAY	HOUSEHOLD NUMBER	Hour of visit	VISIT NUMBER
1	1	8:00-8:15	1
	3	9:30-9:45	1
	5	10:30-10:45	1
	7	11:30-11:45	1
	9	7:00-7:15	1
	11	6:00-6:15	1
	13	13:00-13:15	1
	15	17:30-17:45	1
	17	16:30-16:45	1
	19	18:30-18:45	1
2	21	15:30-15:45	1
	23	14:00-14:15	1
	25	12:00-12:15	1
	2	17:00-17:15	1
	4	16:00-16:15	1
	6	18:00-18:15	1
	8	15:00-15:15	1
	10	6:30-6:45	1
	12	10:00-10:15	1
	14	8:30-8:45	1
3	16	9:00-9:15	1
	18	14:30-14:45	1
	20	11:00-11:15	1
	22	7:30-7:45	1
	24	12:30-12:45	1
	1	16:15-16:30	2
	3	18:15-18:30	2
	5	15:15-15:30	2
	7	10:15-10:30	2
	9	17:45-18:00	2
4	11	17:15-17:30	2
	13	6:45-7:00	2
	15	7:45-8:00	2
	17	11:15-11:30	2
	19	12:15-12:30	2
	21	10:15-10:30	2
	23	8:45-9:00	2
	25	14:45-15:00	2
	2	13:15-13:30	2
	4	15:45-16:00	2
5	6	7:15-7:30	2
	8	6:15-6:30	2
	10	8:15-8:30	2
	12	9:45-10:00	2
	14	14:15-14:30	2
	16	15:45-16:00	2
	18	18:45-19:00	2
	20	16:45-17:00	2
	22	17:45-18:00	2
	24	13:15-13:30	2

The guideline is modular. Depending on the age of the child observed and the time, one, two or all modules can be filled. The breastfeeding session should be observed for children aged 0 to 6 months; the complementary feeding session for children aged 4 to 12 months. The other sessions are not age specific.

<b>General Information</b>	
<b>Province</b>	! ! !
<b>District</b>	! ! !
<b>Village</b>	! ! ! !
<b>Household number</b>	! ! !
<b>Child number</b>	! ! !
<b>Age of the child (months)</b>	! _ ! _ !
<b>Female head of household Y/N</b>	! !
<b>Total number of persons in the household</b>	! ! !
<b>Total number of under 5 in the household</b>	! !

<b>Breastfeeding Practices</b>	Y/N	If yes how many times
<ul style="list-style-type: none"> <li>• Mother breastfeeds</li> <li>• Does the child appear to want to breastfeed?</li> <li>• Does mother allow her child to breastfeed?</li> <li>• Mother gives other fluids besides breast-milk</li> <li>• Mother interrupts breastfeeding session</li> </ul>		
Describe in detailed the breastfeeding session <ul style="list-style-type: none"> <li>• How does the mother hold the child (describe the position)</li> <li>• How is the mouth of the child and the mother's nipple</li> <li>• How's is the suckling of the child?</li> <li>• Do the breasts appear to have been emptied at the feeding?</li> <li>• Does the mother attend to child in other ways?</li> <li>• How is the feeding terminated?</li> <li>• Duration of the feeding session</li> </ul>		
Describe in detailed the other fluids given to the infant:		



<b>Food Preparation</b>	
How is uncooked food stored?	
Is food covered or unprotected?	
Are there any flies or other pests?	
What is done with leftover cooked food? Describe.	
Are dishes and utensils clean?	
Are dishes and utensils stored covered?	
Are there flies or other pests on dishes or utensils?	
<b>Hygiene Practices</b>	
Does caregiver wash hands before cooking infant food	
Does caregiver wash hands before giving food to child?	
Does caregiver wash child's hand before giving him/her food?	
Does the child eat food picked off the ground	
Does the child eat food touched by animals	
Is there infant bottle?	
Caregiver's hands dirty?	
Caregiver's nails not short	
Caregiver's clothes dirty?	
Child's hands dirty?	
Child's face dirty?	
Child's clothe dirty?	
Faeces on ground	
Animals in the house	
Garbage in the living area	
Floor is dirty	
Describe in detail the interiors and exteriors of the household:	



Psychosocial Care	
Is the child swaddled?	
Does the child have an artificial nipple/teat/ pacifier/dummy.	
Do caregiver/s speak to the child?	
What do s/he/they say to the child?	
What tone of voice is used?	
Do caregiver/s show affection to the child?	
In what way (describe)?	
Do caregiver/s show responsiveness to the child?	
In what way (describe)?	
Do you observe any special play equipment or child-centered activity items?	
What item/s? Is it used? By whom?	
Do caregiver show displeasure or scold the child?	
If so, how what this done? (Describe)?	
With which people does the child interact during the visit?	
Briefly describe the child's responsiveness during these interactions.	
<p>How does the child seem to you?</p> <ul style="list-style-type: none"> <li>• Happy and laughing - sad, fussing, crying</li> <li>• Energetic - listless</li> <li>• Curious - disinterested</li> <li>• Trusting and open - fearful, timid, afraid</li> <li>• Calm - quick to show anger</li> </ul> <p>Other (describe):</p>	

## ANNEX 2. REPORTS OF BASELINE ASSESSMENTS

### F. Focus Group Discussions

Note: A total of 288 community members participated in 32 focus group discussions in Andkhoy and Jawzjan. Participants included mothers with children under six months old; mothers and fathers with children 6-24 months old; and women and men who participated in the family planning discussions. Data is still being coded and analyzed at the time of the writing of this document, and the final report is scheduled for the end of June 2004.

Some major findings of the FGDs are:

1. Many families living in Andkhoy cluster encourage pregnant women to attend antenatal care sessions at the basic health centers as compared to a few families in most districts of Jawzjan. Lack of knowledge regarding the importance of antenatal care, lack female staff, long distance to health centers, lack of money for transportation were common reasons mentioned.
2. Mother in laws decide which foods to buy and husbands provide financial resources as well as buy those foods elsewhere that not easily available in the village. Many women and men mentioned that they prepare special food containing energy for pregnant mothers as they believed that special food is important for a mother and baby's health after delivery and for producing milk of adequate quantity.
3. Many family members do not think about making birth preparedness plans. Most common preparations include preparing materials to cover newborns such as clothes, swaddling materials, mattresses and blankets for the baby. Most fathers provide wood and fuel to keep the delivery room warm. They believed that 'heat' facilitates easy delivery and keeps the baby warm. Many family members believe that rest is important for pregnant women but only a few mentioned asking a pregnant women to reduce house chores when she is in her third trimester. Some families save money to buy special food, clothes for the daya (birth attendants) and for doctors and medicines if need be. In Andkhoy, many (both Turkmen and Uzbek identify and discuss with trained birth attendant for her assistance at the time of delivery, ensure that they have a clean birth kit, a soap and a plastic sheet for the delivering mother. They believed that the trained birth attendants understand the complications, have clean and light hands and could manage some problems. When a baby is delivered soon and without complications, such birth attendants are referred to as 'light handed'.
4. Regarding family planning, many believed that this is a sinful and shameful practice and believed that children are gift of God, who has promised to feed them and therefore gives more food if there are more children. There only some who mentioned that they are happy with four or five children and do not want any more children. They believed that more children consume resources and affects the family's economical condition of the family. One Uzbek mother of four children in Qorghan said: *"I think having more children is good, but I think having five or six children is enough. People in this area are poor and cannot bring up more children. Some women are busy weaving carpets and if they get pregnant they stop and the situation [economical] goes down. The more we deliver the more poor we become"*.

Some believed that only a few don't want more children because they are poor and cannot bring up their children properly. Looking after too many children, tiredness and weakness were expressed by some women (both Uzbek and Turkmen) the results of bearing children every year. One forty-five year old woman said: *"My husband and his mother are happy when I bring [give birth to] babies every year. I feel sleepy all the time but I cannot rest. I have to prepare food and feed nine children. I feel very weak and am not as fast [fast to work] as I used to be – my children ate my energy"*.

- Desire for male children is one of the reasons why some women (Uzbek and Turkmen) preferred or felt forced to bear more children. One Uzbek women in Andkhoy said: *"I have four daughters and one son and do not want to deliver again. But my husband says that I must deliver one more time. Maybe Allah will give a son this time"*
- A few especially Uzbek women were using modern family planning methods such as injections and pills. Some Turkmen women and men believed that using FP methods is not only a sin, but harmful such as they cause infertility, swelling and many other women's disease.
- Many (Turkmen and Uzbek) women and men did not know about LAM and mentioned that women give birth *shir ba shir* (from one breastfeeding to another), with most getting pregnant nine to twelve months after birth. Infants are then switched to other milk (cows milk, powder milk and formula) three months before the birth of the next child.
- Most Uzbek and Turkmen women and men didn't know about the sources of family planning methods and information. A few couples wanting to adopt family planning could not do so because they did not know where they are available and considered it shameful to ask people.
- Regarding those who wanted to adopt family planning method and required some information, mentioned that they could get this information from the BHC staff. Some men mentioned that the outreach workers should be trained and provided with information and methods, while a few mentioned that health workers should train mullahs.

## ANNEX 2.G. The “GAP Analysis Tool”

(This is the Gap Analysis Tool used to identify gaps in what is currently being done to improve maternal and newborn survival. CS-19 is implementing this tool at all levels of care to inform the MNC intervention, and the expected completion date is July 2004.)

HOUSEHOLD & COMMUNITY			
What should be at (or done at) the household (HH) & community level to improve maternal and newborn survival?	What is the current practice or activity?	GAP	What more could be done to (and if done effectively) would improve maternal & newborn survival in the HH and community? (i.e. filling the GAP)
Pregnancy (Antenatal period)	Andkhoy is being used as an example. The following does not represent other CS19 areas		
<p><u>Community education</u> on safe motherhood (woman, her family, heads of households, community).</p> <p>a) Encourage ANC with skilled attendant or trained TBA:</p> <p><u>Maternal nutrition</u> and nutritional support. Balanced diet, including giving mothers iron and folate supplementation, malaria prophylaxis, (Vitamin A and Iodine in areas with deficiencies)</p> <p>- Maternal immunization with TT</p> <p>b) Recognition of danger signs and prompt referral by family and or community</p> <p>c) Encourage and support for birth planning or preparedness (emergency funds and transport, identifies blood donor, place of delivery and with whom)</p> <p>d) Support and encouragement for rest</p>			

TBA=refers to a HH or community member who is recognized by the community or HH. The person is not a skilled attendant

HOUSEHOLD & COMMUNITY cont'd			
What should be at (or done at) the household & community level to improve maternal & newborn survival?	What is the current practice or activity?	GAP	What more could be done to (and if done effectively) would improve maternal & newborn survival in the HH and community? (i.e. filling the GAP)
Pregnancy (Antenatal period)			
HH and Community capacity a) Trained community based skilled attendants (where available)  b) Trained TBAs (in areas where a significant number of deliveries are attended by TBAs (training includes strengthening safe normal birthing practices, 3 cleans: hand washing by birth attendant, clean cutting instrument, clean surface, immediate postpartum care of mother and newborn etc).			
<u>Infections:</u> a) Encourage where appropriate syphilis screening and treatment  b) Encourages where appropriate awareness on HIV			

TBA=refers to a HH or community member who is recognized by the community or HH. The person is not a skilled attendant.

HOUSEHOLD & COMMUNITY cont'd			
What should be at (or done at) the household and community level to improve maternal & newborn survival?	What is the current practice or activity?	GAP	What more could be done to (and if done effectively) would improve maternal & newborn survival in the HH and community? (i.e. filling the GAP)
Labor & Delivery			
Trained TBAs or community skilled attendant to manage labor & delivery safely			
Community education on SM			
Safe Management of Labor & Delivery by TBAs (or skilled attendant), including: - Recognition of danger signs/onset of maternal and newborn complications such as post partum hemorrhage, birth asphyxia, fever after delivery, fits, prolonged / obstructed labor - Prompt Referral for treatment			
Hygiene Practices: - Clean hands/hand washing - Clean delivery surface - Clean cord-cutting instrument - Clean perineum - Clean cord care (including cord ties) - Nothing unclean introduced into the vagina			
First aid treatment: - Hydration with oral fluids - Initiation of Early suckling - Encourages passing of urine - External bi-manual compression (BMC) of uterus where appropriate - Use of (oral/IM/IV) oxytocics where appropriate			
What should be at (or done at) the household and community level to improve maternal & newborn survival?	What is the current practice or activity?	GAP	What more could be done to (and if done effectively) would improve maternal & newborn survival in the HH and community? (i.e. filling the GAP)

\*TBA=refers to a HH or community member who is recognized by the community or HH. The person is not a skilled attendant

\*SA=Skilled attendant

HOUSEHOLD & COMMUNITY cont'd			
Labor & Delivery (cont'd)			
Documentation of obstetric complications managed effectively (by type and treatment given) at HH and community level not requiring referral for further management			
Immediate Post Partum			
Post Partum visit by TBAs or community skilled attendant within first 72 hours after delivery (0-6-24hrs, 2nd & 3rd days) Includes: -Vigilance to health status of mother and newborn during immediate postpartum to note any change - Promotion of Immediate and exclusive breastfeeding - Checking for: - Fever - Foul smell (indication of possible onset of infection) -Ability to pass urine - Referral for appropriate treatment for anything abnormal - Vitamin A and Iron supplement (?)			
Post partum at six weeks			
Encouragement to: - Seek family planning counseling & provision - Continue Breast feeding, support & counseling to maintain exclusive BF			

TBA=refers to a HH or community member who is recognized by the community or HH. The person is not a skilled attendant

PERIPHERY & ITS FACILITIES			
What should be at (or done at) peripheral health facilities* to improve maternal and newborn survival?	What is the current practice in the peripheral health facilities?	GAP	What more could be done (and if done effectively) would improve maternal & newborn survival given the level of training of health care providers? (i.e. filling the GAP)
Pregnancy (Antenatal period)			
1. Health workers through ANC provide mothers with nutrition support: - Iron and folate supplementation - Vitamin A & iodine in areas with deficiencies - Advice on nutrition, balanced diet			
Physical examination on each visit: Checking - - Fundal height - Fetal heart beat - Weight - Blood pressure - Urine testing for protein			
Prevention of infections: - Maternal immunization with TT (tetanus toxoid) - Presumptive malaria treatment (in prevalent areas)			
- Encourages use of bed nets - Encourages rest - Encourages personal hygiene			

\* Peripheral facilities include community health centers, basic health center/units, MCH units, health centers private maternity homes etc. (all facilities below the district hospital or district health center as it is called in some countries)



PERIPHERY & ITS FACILITIES cont'd			
What should be at (or done at) the peripheral health facilities to improve maternal and newborn survival?	What is the current practice in peripheral health facilities?	GAP	What more could be done (and if done effectively) would improve maternal & newborn survival given the level of training of health care providers? (i.e. filling the GAP)
Pregnancy (Antenatal period)			
Birth preparedness & planning: Staff help families identify with community systems and encourages birth planning or preparedness (items needed for the birth, emergency funds and transport, identifies blood donor, place of delivery whom with)			
Staff able to detect, manage or refer some complications: - Ante partum hemorrhage - increase high blood pressure - other signs & symptoms of pre-eclampsia ( and as reported by mother) - Ectopic pregnancy - Fever & Infection - abnormal presentations			
Advice and referral to where appropriate on Syphilis screening and treatment			
Advice & referral to where appropriate on screening & testing for HIV			

\* Peripheral facilities include community health centers, basic health center/units, MCH units, health centers private maternity homes etc. (all facilities below the district hospital or district health center as it is called in some countries)

PERIPHERY & ITS FACILITIES cont'd			
What should be at (or done at) the peripheral health facilities to improve maternal and newborn survival?	What is the current practice in peripheral health facilities?	GAP	What more could be done (and if done effectively) would improve maternal & newborn survival given the level of training of health care providers? (i.e. filling the GAP)
Labor & Delivery			
1. Skilled attendants at delivery  2. Observance of Clean delivery practices: hand-washing, clean cutting instrument, clean delivery surface, clean cord ties, clean perineum.  3. Monitoring of labor and safe management of labor and delivery with available: - Partograph - Oxytocin (IM and IV) - Management of preeclampsia with MgSO <sub>4</sub> - IV Fluids (hydration)			
4. <u>Danger signs recognition and management:</u> Staff able to detect, recognize & manage onset of or complication; and refer few complications: - Post partum hemorrhage - Signs & Symptoms eclampsia - Prolonged/obstructed labor, - Fetal distress, Cord prolapse - Fever - Birth asphyxia			

\* Peripheral facilities include community health centers, basic health center/units, MCH units, health centers, private maternity homes etc. (all facilities below the district hospital or district health center as it is called in some countries).

PERIPHERY & ITS FACILITIES cont'd			
What should be done at (or done at) the peripheral health facilities to improve maternal and newborn survival?	What is the current practice in peripheral health facilities?	GAP	What more could be done (and if done effectively) would improve maternal & newborn survival given the level of training of health care providers? (i.e. filling the GAP)
Labor & Delivery cont'd			
<p>1. Skilled health staff able to provide all 6 basic EOC services or some (note how many staff can and are able to provide)</p> <p>Basic EmOC services</p> <p>a - Administer parental antibiotics</p> <p>b - Administer parental oxytocics</p> <p>c - Administer parental anticonvulsants / sedatives for eclampsia/pre-eclampsia (state type)</p> <p>d - Perform manual removal of placenta</p> <p>e - Perform removal of retained products e.g. using Manual vacuum aspiration</p> <p>f -Perform assisted vaginal delivery (with forceps or by vacuum extraction)</p> <p>Perform other life saving procedures:</p> <p>- External bi-manual compression of uterus</p> <p>- Internal bi-manual compression of uterus (with observation of aseptic techniques)</p>			

PERIPHERY & ITS FACILITIES cont'd			
What should be at (or done at) the peripheral health facilities to improve maternal and newborn survival?	What is the current practice in peripheral health facilities?	GAP	What more could be done (and if done effectively) would improve maternal & newborn survival given the level of training of health care providers? (i.e. filling the GAP)
Labor & Delivery (cont'd)			
24/7 service availability			
Documentation of obstetric cases managed effectively at peripheral facility (by type and treatment given) not requiring referral for further management			
The enabling environment (resources for service delivery)			
Essential equipment & supplies to perform the basic EmOC services			
Revolving drug fund (or a system in place to ensure 24/7 availability of essential drugs)			
Transport & communication links to nearest referral facility			
Immediate Post partum care			
Post Partum care by skilled attendant in facility or by home visit OR Postpartum care by TBA -- within the first 72 hours after delivery (0-6-24hrs, 2nd & 3rd days) Includes:			

\* Peripheral facilities include community health centers, basic health center/units, MCH units, health centers, private maternity homes etc. (all facilities below the district hospital or district health center as it is called in some countries)

PERIPHERY & ITS FACILITIES cont'd			
What should be at (or done at) the peripheral health facilities to improve maternal and newborn survival?	What is the current practice in peripheral health facilities?	GAP	What more could be done (and if done effectively) would improve maternal & newborn survival given the level of training of health care providers? (i.e. filling the GAP)
Immediate Post partum care (cont'd)			
<ul style="list-style-type: none"> <li>-Vigilance to health status of mother and newborn during immediate postpartum to note any changes</li> <li>- Promotion of immediate and exclusive breastfeeding</li> <li>- Checking for: <ul style="list-style-type: none"> <li>- Fever</li> <li>- Foul smell (indication of possible onset of infection)</li> </ul> </li> <li>-Ability to pass urine</li>   <li>- Treatment of any ailment as appropriate by skilled attendant</li> <li>- Referral for treatment by TBA</li>   <li>- Vitamin A and Iron supplement (?)</li> <li>- FP counseling &amp; provision (where available)</li> </ul>			
Postpartum care at six weeks			
1. Family planning counseling & provision  2. Breast feeding support & counseling to maintain exclusive breastfeeding			

\* Peripheral facilities include community health centers, basic health center/units, MCH units, health centers, private maternity homes etc. (all facilities below the district hospital or district health center as it is called in some countries).

DISTRICT HOSPITAL (or referral facility)			
What should be done at (or done at) the district hospital to improve maternal and newborn survival?	What is the current practice at the district hospital	GAP	What more could be done (and if done effectively) would improve maternal & newborn survival given the level of training of health care providers? (i.e. filling the GAP)
Pregnancy (Antenatal period)			
(Builds on what HH & community and peripheral facilities do)			
1. Health workers through ANC provide mothers with nutrition support including: - Iron and folate supplementation - Vitamin A & iodine in areas with deficiencies - Advice on nutrition, balanced diet			
Physical examination on each visit. Checking - - fundal height - fetal heart beat - weight - blood pressure - urine testing for protein			
Prevention of infections: - Maternal immunization with TT (tetanus toxoid) - Presumptive malaria treatment (in prevalent areas)			
- Encourages use of bed nets - Encourages rest - Encourages personal hygiene			

DISTRICT HOSPITAL (or referral facility)			
What should be at (or done at) the district hospital to improve maternal and newborn survival?	What is the current practice at the district hospital?	GAP	What more could be done (and if done effectively) would improve maternal & newborn survival given the level of training of health care providers? (i.e. filling the GAP)
Pregnancy (Antenatal period)			
Birth preparedness & planning:  Staff help families identify with community systems and encourages birth planning or preparedness (items needed for the birth, emergency funds and transport, identifies blood donor, place of delivery whom with)			
Staff have capacity and skill to detect and manage all (or most) obstetric complications:  - Ante partum hemorrhage - Pre-eclampsia - Ectopic pregnancy - Fever and Infection - Mal-presentations - Other complications			
Resources to provide Syphilis screening & treatment where appropriate			
Resources to Provide VCT for HIV where appropriate & available			

DISTRICT HOSPITAL (or referral facility)			
What should be at (or done at) the district hospital to improve maternal and newborn survival?	What is the current practice at the district hospital?	GAP	What more could be done (and if done effectively) would improve maternal & newborn survival given the level of training of health care providers? (i.e. filling the GAP)
Labor & Delivery			
1. Skilled attendants at delivery			
2. Observance of Clean delivery practices: hand-washing, clean cutting instrument, clean delivery surface, clean cord ties, clean perineum.			
3. Monitoring of labor and safe management of labor and delivery with: - Partograph, - Oxytocin (IM and IV) - IV Fluids (hydration) - Management of preeclampsia with MgSO <sub>4</sub> - Other			
4. <u>Danger signs recognition and management</u> : Staff able to detect, recognize and manage obstetric complications effectively: - prolonged/obstructed labor - signs of imminent uterine rupture / ruptured uterus - post partum hemorrhage - elevated BP, eclampsia and post eclampsia - infection, fever, - cord prolapse, fetal distress - birth asphyxia			



DISTRICT HOSPITAL (or referral facility)			
What should be at (or done at) the district hospital to improve maternal and newborn survival?	What is the current practice at the district hospital?	GAP	What more could be done (and if done effectively) would improve maternal & newborn survival given the level of training of health care providers? (i.e. filling the GAP)
Labor & Delivery (cont'd)			
<p>Life saving services should be available at the district hospital</p> <p>1. Skilled health staff to provide <u>Comprehensive emergency obstetric care (8 guiding components)</u>:</p> <p>a - Administer parental antibiotics</p> <p>b - Administer parental oxytocics</p> <p>c - Administer parental anticonvulsants / sedatives for eclampsia/pre-eclampsia (state type)</p> <p>d - Perform manual removal of placenta</p> <p>e - Perform removal of retained products e.g. with Manual vacuum aspiration</p> <p>f - Perform assisted vaginal deliveries (with forceps or by vacuum extraction)</p> <p>g - Perform surgery i.e. cesarean section</p> <p>h - Perform/Administer safe blood transfusion</p> <p>Perform other life saving procedures:</p> <ul style="list-style-type: none"> <li>- External bi-manual compression of uterus</li> <li>- Internal bi-manual compression of uterus (with observation of aseptic techniques)</li> </ul>			

DISTRICT HOSPITAL (or referral facility)			
What should be at (or done at) the district hospital to improve maternal and newborn survival?	What is the current practice at the district hospital?	GAP	What more could be done (and if done effectively) would improve maternal & newborn survival given the level of training of health care providers? (i.e. filling the GAP)
24/7 service availability			
Documentation of obstetric cases managed effectively at peripheral facility (by type and treatment given) not requiring referral for further management			
The enabling environment (resources for service delivery)			
1. Availability of surgery facilities: - Operating theatre - Anesthesiologist (doctor/nurse/paramedical staff) - Anesthetic equipment - Resuscitation equipment (respirator, aspirator etc) - Essential equipment for surgery - Essential supplies (gauze, bandage etc) - Essential drugs (and revolving drug fund or system in place to ensure 24/7 availability)			
2. Functioning blood bank services (screening, storage facilities, transfusions, replacement)			
3. Transport & communication links to nearest provincial facility & the peripheral facilities			

DISTRICT HOSPITAL (or referral facility)			
What should be at (or done at) the district hospital to improve maternal and newborn survival?	What is the current practice at the district hospital?	GAP	What more could be done (and if done effectively) would improve maternal & newborn survival given the level of training of health care providers? (i.e. filling the GAP)
Immediate post partum care			
By health worker or TBA or HH help  -Vigilance to health status of mother and newborn during immediate postpartum to note any changes - Promotion of immediate and exclusive breastfeeding - Checking for: - Fever - Foul smell (indication of possible onset of infection) -Ability to pass urine  - Treatment of any ailment as appropriate by skilled attendant - Referral for treatment by TBA or HH - Vitamin A and Iron supplement (?)  - FP counseling and provision			
Post partum care at six weeks			
Family Planning counseling & provision			
Breastfeeding counseling to maintain exclusive BF			

## **Monitoring and Evaluation**

Focus should cover the areas of:

- Availability
  - Utilization
  - Quality
1. What indicators are available to measure ANC, community education, referral by TBAs to peripheral facilities or other places?
  2. Which process indicators are being used?
  3. Is there provision for documentation of experiences at the HH and community? Is so detail.
  4. Are the records / registers in the facilities capturing vital information such as age, education, income, diagnosis, treatment, outcomes, feedback to the HH/community –from district hospital to peripheral facility?
  5. Are there any strengthening of district structures that influence or will influence the program?

**ANNEX 3. REVISED AGREEMENT BETWEEN SC AND MOH, JAWZJAN**  
(Draft of original, signed document to be added to the DIP by June 30)

Basic Terms of Agreement

Between

SAVE THE CHILDREN FEDERATION, INC. (hereafter referred to as SC), which is a private non-profit, voluntary organization engaged in humanitarian assistance and development projects. The principle office is located in 54 Wilton Road, Westport, Connecticut 06880. The head office in Afghanistan is located in Darul Aman Main Road, Sherkat Bus Stop, Ayoub Khan Mina in Kabul, Afghanistan and is represented by Lisa Laumann, Country Director.

And

The MINISTRY OF HEALTH, Jawzjan Province, Islamic Transitional Government of Afghanistan (hereafter referred as MOH.)

Whereas Save The Children Federation, Inc. is dedicated to improving the quality of life of children and mothers in Afghanistan.

Whereas the MOH has expressed its desire to engage and associate with non-governmental organizations to carry out its primary health policies of health care and essential drugs in favor of women and children.

Whereas the Government of Afghanistan and Save the Children Federation, Inc have signed a cooperative agreement for implementation of the project “Child Survival 19” within the context of the national health policies and plan of action.

For the purposes and convenience of the two parties, the following have been set forth below:

I. DEFINITION OF PROJECT

This Agreement outlines the roles and responsibilities of both sides in the implementation of the Child Survival project (CS-19) in Jawzjan Province, which supports the MOH in providing the Basic Package of Health Services throughout Jawzjan.

The goal of CS-19 is to achieve a sustained reduction in under-five and maternal mortality in Jawzjan, which will be met through the achievement of the following strategic objective:

Improved health practices at household level, and increased use of essential MCH services.

This strategic objective will be met by achievement of the following intermediate results (IR):

- IR-1: Increased household-level knowledge of essential MCH practices in Jawzjan Province;
- IR-2: Increased access to essential MCH services in Jawzjan Province;
- IR-3: Increased quality of essential MCH services in Jawzjan Province; and
- IR-4: Established social network to support key behaviors.

These results will be achieved through support to the MOH in Jawzjan in the following key intervention areas:

1. Immunization
2. Nutrition
3. Control of Diarrheal Diseases
4. Pneumonia Case Management
5. Maternal and Newborn Care

These interventions will be implemented through the following four major cross-cutting **strategies**:

1. Provincial-level strengthening of the MOH in Jawzjan through training, capacity-building of the PHO, and supervision to effectively support the BPHS;
2. Health behavior change activities through health facility staff, CHWs, mullahs, teachers, children, and local radio;
3. SC/MOH engagement with health sector partners to leverage resources in support of essential MCH activities in Jawzjan; and
4. Testing innovative approaches to improving access, quality, and use of essential MCH services; documentation and dissemination of feasibility and results; and scaling-up of successful approaches:
  - Community Defined Quality (CDQ): Working with community members and health staff to understand and improve the quality of MCH services from the community perspective, and to increase use of essential health services by community members; and
  - Community Case Management (CCM): Increasing community access to and prompt use of life-saving treatment for childhood diarrhea and pneumonia by training and supporting CHWs to provide this service in areas with poor access.

## 2. ROLES AND RESPONSIBILITIES

SC will:

- ✧ Ensure appropriation of implementing Child Survival project in Jawzjan Province and the Andkhoy Cluster to existing policy and strategy of the MOH concerning maternal and child health issues.
- ✧ Assure the financing of SC-initiated project activities subject to the availability of funds.
- ✧ Conduct monthly monitoring of CS-19.
- ✧ Provide annual reports to the MOH.
- ✧ Take the lead role in the development and implementation of baseline and endline surveys.
- ✧ Develop or obtain appropriate training materials for CS-19 interventions.
- ✧ Coordinate and collaborate with health staff working in REACH target areas.
- ✧ Develop or obtain appropriate education materials for CS-19 intervention areas.
- ✧ Ensure that CS19 interventions and activities support the MOH Basic Package of Health Services and other policies (e.g. Safe Motherhood Policy.)
- ✧ Provide the required equipment and supplies for trainings to the training sites.
- ✧ Strive to strengthen the capacity of the MOH and communities to implement and manage CS-19 related interventions.

- ✧ Involve the local counterparts in the periodical reviews of CS-19.
- ✧ Implement the project activities following Detailed Implementation Plan (DIP), a copy of which will be given to the MOH. SC will keep the MOH informed of any significant modification made to this plan.
- ✧ Represent CS-19 at monthly Provincial Health Coordination Committee meetings.
- ✧ Regularly discuss, seek PHCC support for, and report on CS-19 major activities at PHCC meetings.

The MOH will:

- ✧ Provide the necessary support for SC to implement CS-19 within Jawzjan Province and the Andkhoy Cluster Districts.
- ✧ Direct its staff at all health facilities to provide the necessary cooperation and support for CS-19 to carry out its planned activities.
- ✧ Provide training sites for planned TOTs and other trainings.
- ✧ Advise its appropriate technical staff to attend the relevant trainings provided by CS-19.
- ✧ Ensure that REACH-funded and CS-19-supported MOH staff provide trainings to facility level staff, participate in Operations Research and other community-based activities.
- ✧ Plan and conduct joint monitoring and supervisory visits with SC project personnel.
- ✧ Share relevant information with SC on the future health plans.
- ✧ Provide SC with constructive feedback on reports submitted by the project in writing.

The present terms of agreement are for a period of five years and become effective upon the date of the signature. It can be amended by common accord of both parties.

\_\_\_\_\_  
Provincial Health Director, MOH

\_\_\_\_\_  
SC Program Representative

Date \_\_\_\_\_

Date \_\_\_\_\_

(Note: The original, signed version of this document will be inserted into the DIP at the Mini-University in June, 2004)

#### **ANNEX 4. CS-19 DIP Workshop Agenda and List of Participants**

<b>Time</b>	<b>Activity</b>
<b>March 10: Day 1</b>	
10:10-10:10	Recitation of Holy Quran
10:15-10:30	Opening remarks by Dr. Haroon
10:30-11:00	Introduction to workshop
11:00-11:15	Objectives of workshop
11:15-11:45	Child Survival Programs and the SC/US Experience
11:45-12:15	MCH Programs in Jawzjan
12:15-1:00	Presentation of Organizations
1:00-1:45	Lunch
1:45-2:15	Innovative Approaches in CS-19
2:15-3:00	Cross-Cutting Strategies and Leveraging Resources
<b>March 11: Day 2</b>	
9:00-10:00	REACH Program
10:00-11:00	Review and refine CS-19 Interventions/Approaches
11:00-12:30	Group presentations by Intervention
12:30-1:30	Lunch
1:30-3:00	Agreement on CS-19 Revisions
3:00-3:30	Next Steps



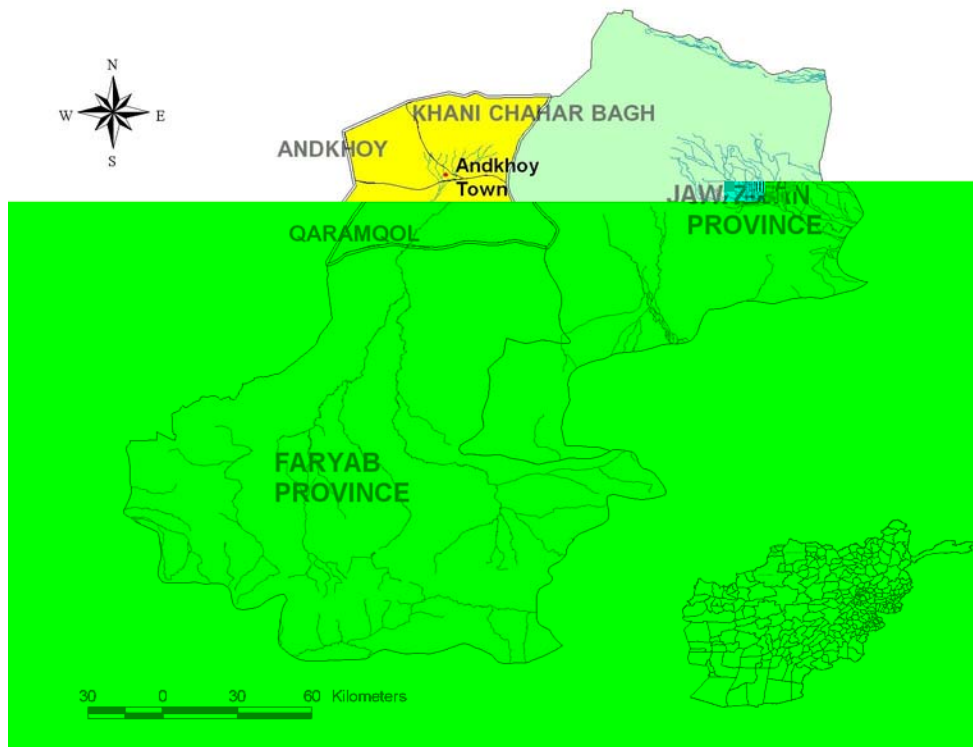
**CS-19 DIP Workshop Attendance Sheet**  
**Shibergan Hospital, Jawzjan District**  
**March 10-11, 2004**

<b>Name</b>	<b>Title</b>	<b>Organization</b>
1. Kathryn Bolles	Child Survival Specialist	Save The Children/US
2. Dr. Aftab Tariq	Regional Health Advisor	SC/US
3. Dr. Mohammed Honey	CS-19 Project Manager	SC/US
4. Dr. Said Habullah Deilus	Health Officer, Andkhoy	SC/US
5. Dr. Alemi	Sr Health Officer	SC/US
6. Dr. Rahila	Female Sr Health Officer	SC/US
7. Dr. Basir Mawlawizada	Nutrition Coordinator	SC/UK
8. Dr. Mirwais Amini	Deputy Director	MOH Jawzjan
9. Dr. Haron Arif	Provincial Health Director	MOH Jawzjan
10. Dr. M. Anwar Kasili	HMIS Officer	MOH, Jawzjan
11. Dr. Bakhter Rasekh	Environmental Health Officer	MOH, Jawzjan
12. Dr. Muiasar Habibi	Gynecology Ward	MOH Jawzjan
13. Dr. M. Y. Ghani	Internist	MOH Jawzjan
14. Dr. A. Ghafoor Ahulti	Malaria Dept	MOH Jawzjan
15. Mohammed Anwar	Administrator	MOH Jawzjan
16. Dr. Ab. Ghafoori	TB Center	MOH Jawzjan
17. Dr. Sarajuddin Opghan	Chief of Surgery, Shibergan	MOH Jawzjan
18. Dr. Maidani	Pediatrician	MOH Jawzjan
19. Dr. M. Yasser	Provincial Mgmt. Team	MOH Jawzjan
20. Dr. Mina	Female Health Officer	MOH Jawzjan-SC/US
21. Dr. Ralimatullha	MOH Director, Andkhoy	MOH, Andkhoy
22. Dr. Habib	Deputy Director, Provincial Hlth	MOH Kabul
23. Pirjorihia V-Raelarha	Program Manager	ICRC*
24. Dr. Maritz R.	Gynecologist	ICRC
25. Dr. Rokai	Medical Field Officer	ICRC
26. Elisa Yllo	Midwife	ICRC
27. Dr. Homaira	Field Officer	ICRC
28. Dr. Deepak Kalsa	Director	Indian Medical Mission
29. Jules Gaden	Director	CDI
30. Alenira Moreira Santos		CDI
31. Paul Fishstein		MSH/REACH
32. Dr. Ahmad Wali	Provincial Health Advisor	MSH/REACH
33. Dr. Iqbalshah Pakzad	Community Health Advisor	MSH/REACH
34. Homaira Hanif	Provincial Support Officer	MSH/REACH
35. Dr. _____		WHO
36. Farid Ahmad Dastgeer	Assistant Project Officer	UNICEF

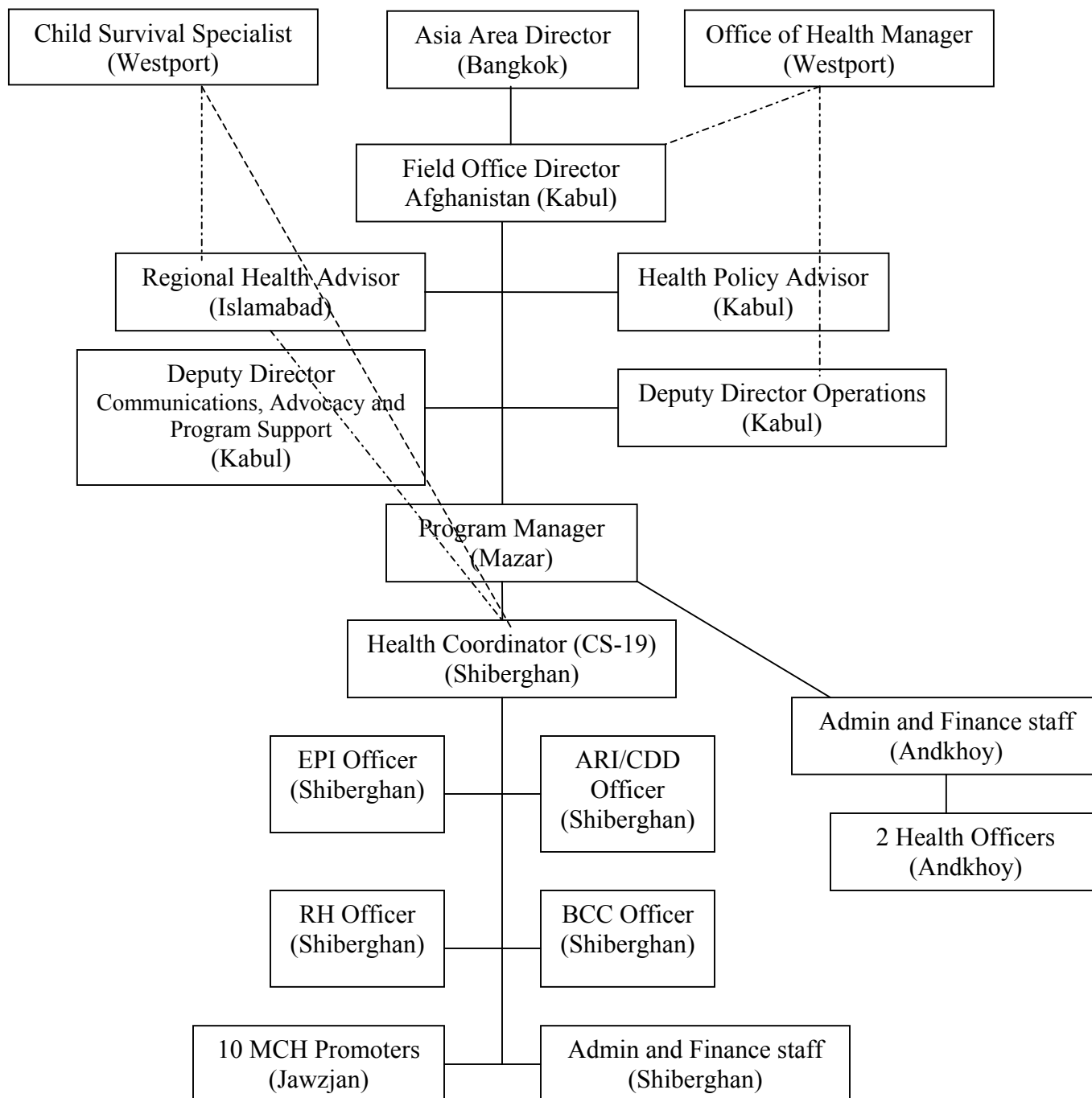
\*ICRC=International Committee for Red Cross, CDI=Crosslink Development International, MSH=Management Sciences forHealth

## ANNEX 5.

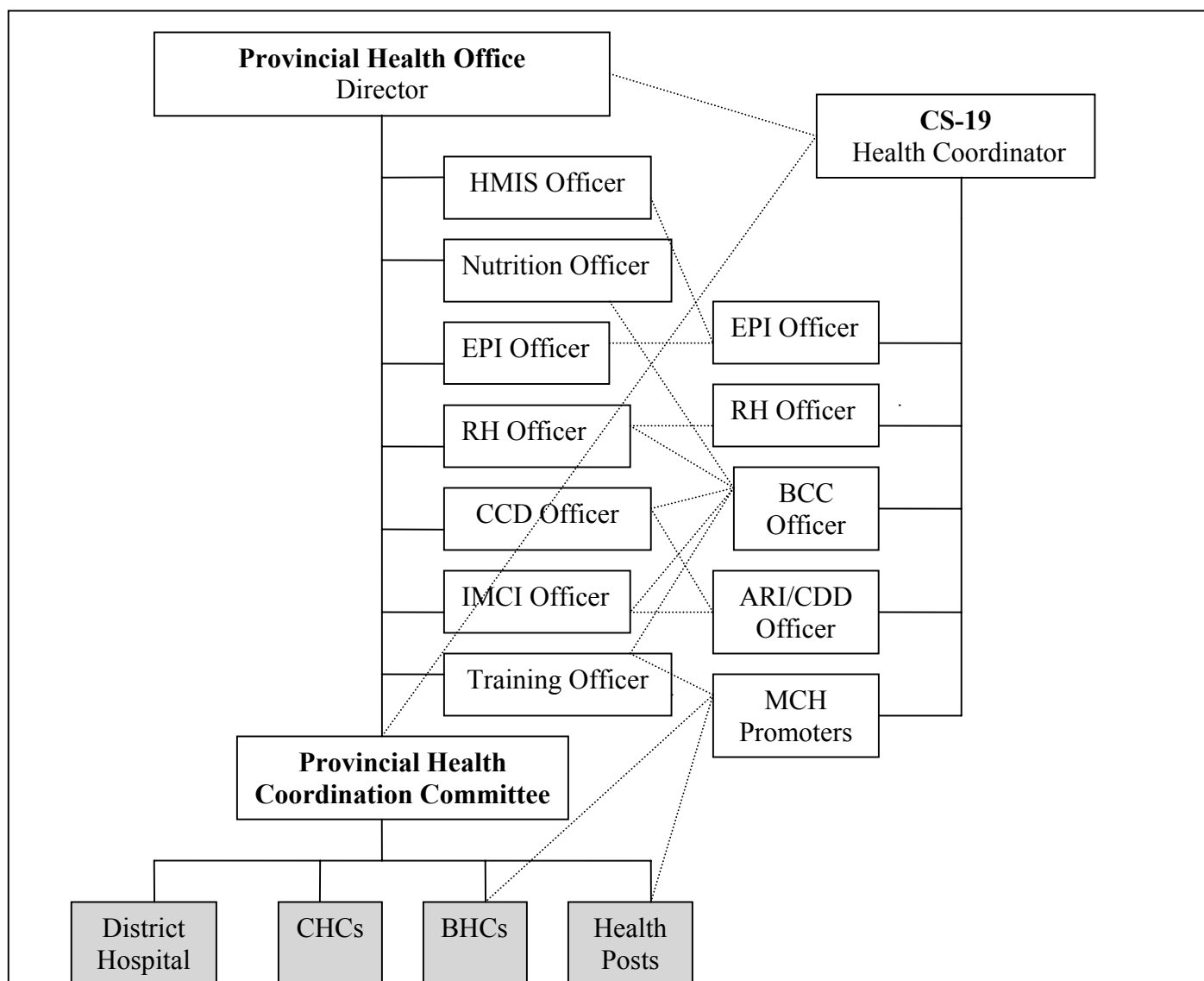
### MAP OF AFGHANISTAN AND CS-19 SITES



**ANNEX 6.**  
**SC CS-19 REVISED ORGANIZATIONAL CHART**



## ANNEX 7. DIAGRAM OF CS-19 AND RELATED MOH AND REACH COUNTERPARTS



The **Provincial Health Office** will plan and oversee all applications of the BPHS, the current national health policy. CS-19 technical staff is shown in the diagram above with the PHO counterparts. *CS-19 will provide technical training to PHO counterparts, and participate in joint planning and supervision of all MCH activities in the BPHS.*

The **Provincial Health Coordination Committee** will coordinate all stakeholder activities in achieving MOH priorities, particularly BPHS. They will draft provincial plans, assign catchment areas, review proposals, and coordinate HMIS data. *The CS-19 Coordinator serves as Secretary of this Committee and will participate in all PHCC tasks.*

**REACH**-funded facilities providing BPHS are shown in the shaded boxes above. *CS-19 will play an active role in the planning, monitoring and evaluation of activities at facility sites, and will provide trainings as needed for facility staff, including health volunteers. CS-19 MCH promoters will be based in the villages, and will work with REACH staff at the health post and BHC levels.*

## ANNEX 8. CVs OF CS-19 KEY PERSONNEL

### A. KATHRYN BOLLES (Child Survival Specialist)

Kathryn Bolles has extensive experience in health program design and management in a variety of populations and geographic areas. She directed a community-based maternal and child health program in Haiti for over 3 years, overseeing operations and supervising the administrative and field staff in program implementation. Ms Bolles has also provided technical support to domestic and international programs, including design, monitoring and evaluation, operational research, proposal development, board development and fundraising. She created a health-information system in Haiti that included vital registration of mothers and children in a district with 200,000 people. Ms. Bolles has a background in group facilitation, training and peer education, and has developed HIV/AIDS training manuals for marginalized populations in Tennessee. She has also consulted on a number of short-term international projects in the fields of both maternal and child health and HIV/AIDS.

*LANGUAGE ABILITY:* English-native; French-fluent; Haitian Creole-fluent; Spanish-fluent.

*CURRENT POSITION:* Child Survival Specialist, Save the Children Federation, Inc., Westport, CT.

#### *RELEVANT EDUCATIONAL BACKGROUND*

Master of Public Health, International Health, Emory University, 2000.

Bachelor of Arts, French Language, University of Georgia, 1993.

#### *RELEVANT WORK EXPERIENCE*

***Child Survival Specialist, Save the Children Federation, Inc., Westport CT, September 2003 – Present.*** Design, plan, and support international maternal and child health programs, including strengthening program quality and capacity of in-country colleagues.

***Executive Director, Nutrition Program, Hôpital Sainte Croix Leogane, Haiti, July 2000 - September 2003.*** Grant writing, fundraising, budgeting, board development and facilitating relationships with US and Haitian organizations. Programmatic responsibilities included supervising a 32-person staff in Haiti, and designing, implementing and evaluating all project activities. Current projects include micro-credit for women, Positive Deviance/Hearth, ongoing nutritional surveillance, and safe water systems.

***HIV Education Programs Coordinator, Chattanooga CARES: AIDS Resource Center, Chattanooga TN, July 1996 – August 1998.*** Development, implementation, and evaluation of all agency programs, design and maintenance of the AIDS resource library, the agency website, staff training, and English/Spanish translation. Coverage area included the Tennessee Valley and Appalachia.

***HIV Youth Education Coordinator, Chattanooga CARES, Chattanooga TN, August 1994 – July 1996.*** Development, implementation, and evaluation of all youth education programs; developed training manuals; led training of peer educators and education volunteers; bilingual prevention education; and informing staff of the latest technological and biomedical developments.

### **Short-term Work**

***Consultant, CARE, Atlanta GA, October 1999 – May 2000.*** Charted a history of CARE child survival (CS) projects and researched cost-effectiveness of past and future CS initiatives in developing countries. Assisted in reviewing, editing and researching USAID Child Survival Grant awards and proposals.

***Consultant-Health Finance, MARCH/CITIMED, Haiti, October 1999.*** Performed cost-recovery scenarios for 5 clinics in Haiti with new user fee system. Developed database for patient entry and financial records.

***Statewide HIV Needs Assessment Assistant, Southeast AIDS Training and Education Center, Emory University, Atlanta GA, December 1998 – June 1999.*** Assisted in coordination of the State of GA 1999 HIV/AIDS Needs Assessment for service providers.

***Consultant-HIV/AIDS, PSI Guatemala, June 1999 – August 1999.*** Conducted qualitative HIV/AIDS research with sex workers, truck drivers and adolescent populations. Developed three reports for NGOs with recommendations for prevention program development to be implemented in Guatemala, Panama, Costa Rica, Belize, Honduras and Nicaragua.

### ***RELEVANT PAPERS/PUBLICATIONS***

Bolles, K, Speraw, C, Berggren G, Lafontant, J. Ti foyer (Hearth) community-based nutrition activities informed by the positive deviance approach in Leogane, Haiti: a programmatic description. Food Nutr Bull 2002; 23 (4 Suppl): 11-17.

“Conocimientos, actitudes y practicas sobre el sexo, el uso del condón, y VIH/SIDA en trailers de las fronteras con Mexico y Belice” (Knowledge, attitudes and practices regarding sex, condom use and HIV/AIDS in truckers along the Mexican and Belice borders) report to PSI, Washington, August 1999.

“Conocimientos, actitudes y practicas sobre el sexo, el uso del condón, y VIH/SIDA en trabajadoras del sexo en las fronteras de Guatemala” (Knowledge, Attitudes and Practices regarding sex, condom use and HIV/AIDS in female sex workers in two border towns in Guatemala), report to PSI, Washington, August 1999.

HIV/AIDS Peer Education Program Manual. Chattanooga CARES: AIDS Resource Center, March 1995.

PACT: HIV/AIDS Prevention Education Manual. Chattanooga CARES: AIDS Resource Center, October 1994.

**B. HONEY MOHAMMED**  
**(CS-19 Health Coordinator)**

**EDUCATIONAL BACKGROUND:**

MD, 1996. Faculty of Medicine, Balkh University, Balkh, Afghanistan.

**PROFESSIONAL BACKGROUND:**

- 6/2001 - Present**      **Senior Project Officer, Health,** Save the Children US. Established Save the Children sub-office in Sherberghan City, Afghanistan. Managed the Acute Respiratory Infections/Control of Diarrheal Diseases (ARI/CDD) project and the Child Focused Health Education (CFHE) program. Supervised health staff of 5 and 120 Community Health Volunteers. Currently the Project Manager for CS-19.
- 1/2001 - 6/2001**      **Medical Doctor,** International Assistance Mission. Worked as a medical doctor at the Mazar Ophthalmic Center in Mazar City, Afghanistan. Examined patients, tracked eye diseases among refugee population and performed surgery.
- 1/1997 - 12/2001**      **Clinic Head,** Swedish Committee for Afghanistan. Managed clinic, provided training to community health workers, and supervised national immunization campaigns. Introduced primary health care components such as health education, essential drugs and maternal and child health. Supervised health staff of 6.

**AREAS OF SKILLS AND EXPERIENCE:**

**Primary Health Care with Emphasis in Maternal and Child Health:** Assist with program and financial management of maternal and child health projects, including facilitating the establishment of a Save the Children sub-office in Sherberghan city. This program focuses on ARI/DD case management. Worked as head of clinic responsible for patient care and examinations, disease detection and treatment, ensuring adequate supply and distribution of pharmaceutical supplies for the pediatric ward.

**Needs Assessment and Surveys:** Conduct surveys using both quantitative and qualitative methods to assess the impact of health program interventions and to appraise the knowledge, attitudes, and practices among community members. This includes collecting baseline data related to ARI/CDD, mapping targeted areas and conducting program monitoring and evaluation. Conducted EPI surveys and CDD campaigns in Khoja Dokoh/Sherberghan districts, and participated in trainings and monitoring of National Immunization Days addressing polio eradication and measles mortality reduction. Worked closely on the collection, analysis and dissemination of HIS data.

**Liaison with Government, NGOs, and UN Agencies:** Liaise with Government of Afghanistan health department officials, NGOs, UN, and bilateral agencies to coordinate maternal and child health activities and train Ministry of Health staff to provide case management following WHO guidelines. Worked closely with partners in the monitoring and management of emergency centers in response to Cholera outbreaks. Coordinate activities with the government, the UN and other agencies to actively support their participation in sectoral and provincial meetings.

**Technical Training:** Conducted trainings for MOH doctors, nurses and pharmacists on case management as per WHO guidelines on topics such as ARI/CDD, immunization, breastfeeding, nutrition, health education and teaching methodologies. Provided training for Community Health Volunteers and health educators on home visits and child focused health education programs. Participated in nutrition surveillance training. Developed and implemented training for community health workers to provide health education in both a health facility and community settings and established a referral system between the community and the clinic. Received training on Integrated Management of Childhood Illnesses.

**Concept Paper and Proposal Writing:**

Participated in the planning, strategic development and the writing of the ARI/CDD proposal and reports for Save the Children's work in Afghanistan. Participated in Save the Children's CS-19 MCH project planning.

**LANGUAGES**

English (excellent)

Dari (excellent)

Uzbeki (excellent)

Turkmeny (excellent)

Pashto (good)



**C. KIMBERLY ALLEN**  
**(Program Manager in Balk and Jawzjan Provinces)**

**Professional Experience**

Program Manager, SC/US, Northern Afghanistan

-Manage Health programs and projects in Balk and Jawzjan Provinces.

Prevention Coordinator - Alcohol and Drug Program 2001-2004

County of Santa Cruz, Santa Cruz, California

- Manage alcohol and drug prevention program activities throughout County including: supervising three youth- outreach program staff; preparation of annual work plans and budgets; negotiation of sub-contracts with local community-based organizations. County annual budget totals approximately \$300,000.
- Manage Federal Safe and Drug Free Schools and Communities Grant worth \$200,000 per year for 3 years. Duties include: preparing quarterly reports; strategic planning and preparation annual work plans in coordination with strategic planning team.
- Prepared and field-tested Party Guidelines pamphlets for both youth and parents. Review and procure drug and alcohol educational videos, books and pamphlets for target audiences. Organize guest speakers.
- Participate in local, regional and national drug, alcohol and tobacco coalitions.

Asia Near East Regional Coordinator - MOST, The USAID Micronutrient Project 1999-2000  
International Science and Technology Institute, Inc., Arlington, Virginia

- Managed regional and country activities in accordance with U.S. Agency for International Development (USAID) and corporate procedures. Countries included; Bangladesh, India, Morocco, Nepal and The Philippines.
- Prepared country plans and budgets; provided in-country technical assistance; and wrote, negotiated, and managed subcontracts. Country budgets totaled approximately \$2.5 million.

Child Survival and Nutrition Advisor - USAID/Nepal 1997-1998

Health and Child Survival Fellows Program, Johns Hopkins University, Baltimore, Maryland

- Planned, documented, monitored and evaluated USAID-supported child survival and nutrition activities in Nepal.
- Advised the National Vitamin A Program and the Acute Respiratory Infections (ARI) Strengthening Program. USAID program funding totaled approximately \$3 million.
- Wrote annual Ministry of Health (MOH)/donor work plans and budgets; reviewed proposals for technical content; coordinated child survival and nutrition activities between the MOH and non-government organizations.
- Prepared five-year strategy for the expansion of ARI program within the context of WHO Integrated Management of Childhood Illness (IMCI) Program.

Program Associate - Family Planning Logistics Management Project 1996

John Snow, Inc., Arlington, Virginia

- Managed funds and backstopped field activities in five countries: Kenya, Malawi, Nepal, Uganda, and Zambia. County budgets managed totaled approximately \$1.5 million.

Research Assistant - All Kids Count Project 1996

San Diego County Health Department, San Diego, California

- Trained medical assistants in seven of the 12 County Community Health Clinics in the use of the All Kids Count Immunization information system, performed data integrity checking, and provided feedback to clinic managers and system users.

Technical Advisor-CDD/ARI Section, Ministry of Health 1994-1995

John Snow, Inc., Kathmandu, Nepal

- Designed and wrote ARI Manual for Community-Level Health Workers including; curriculum for Trainer's Guide, recording/reporting and referral forms, and treatment and home therapy cards in collaboration with the CDD/ARI Section, UNICEF, WHO and John Snow, Inc.
- Prepared pre-testing guidelines for ARI manual and performed field testing; and organized orientation and training activities for the MOH program. Training design and materials are the basis for Nepal's Community-based IMCI Program and are currently in use today.

Field Advisor - Jumla Community Health Project 1992-1994

Dartmouth Medical School, Jumla, Nepal

- Designed, wrote the curriculum for, and coordinated implementation of child survival intervention basic and refresher trainings for supervisors and field-workers in child pneumonia and diarrhea case management, vitamin A supplementation, childhood immunization, nutrition, and family planning.
- Developed and strengthened supervisory systems for office and field staff. Conducted extensive fieldwork in remote villages, including evaluation of the effectiveness of field-workers' interventions within the community.
- Compiled, analyzed, and utilized intervention data. Trained Nepali counterparts in proper analysis and information management techniques.
- Evaluated the use of antibiotic tablets instead of syrup for the treatment of acute respiratory infections.
- Carried out a district immunization coverage survey, which included training field supervisors and surveyors in WHO survey guidelines; compiling and analyzing data; and writing preliminary and follow-up reports.

Information Specialist - Tobacco Research Project 1992

Department of Behavior and Community Health, Graduate School of Public Health, San Diego State University

- Provided key information from the Smoking Control Advocacy Resource Center, Washington D.C., and other sources to project managers
- Compiled and analyzed data from Native American smoking behavior survey using SPSS; and analyzed California census data with regard to smoking behavior.

Teacher/Teacher Trainer 1988-1990

U.S. Peace Corps, Jhapa District, Nepal

- Taught English, mathematics, and science to rural high school students.
- Conducted and evaluated a 12-day English language training; and designed, implemented, and evaluated English language workshops for local primary school teachers.
- Conducted a feasibility study and wrote the budget and implementation proposals for a health post.

## **Consultancies**

### **1. Kanchanpur Child Survival Project - Mid-term Evaluation Team Leader 2001**

CARE, Atlanta, Georgia and Kathmandu, Nepal

- Used USAID/BHR/PVC mid-term evaluation guidelines to evaluate project implementation activities such as nutrition, child feeding, CDD and ARI. Conducted field visits and meetings with project staff, female community health workers, government health staff and local leaders; reviewed reports; analyzed qualitative data; presented preliminary findings and prepared final report.

### **2. Women's Health in Nepal and Child Survival IX Projects 1995**

Adventist Development and Relief Agency, Kavre District, Nepal

- Recruited project staff, prepared proposals, quarterly, semiannual, and annual reports; conducted field visits in order to evaluate the quality and effectiveness of program activities; launched a drug cost-recovery pilot project in a village of Kavre District. The pilot has since been adapted and expanded in other villages.

### **3. John Snow, Inc., Kathmandu, Nepal 1994**

- Coordinated the collection of health materials produced in Nepal that contain messages about essential and rational use of drugs. Activities included creating a system and forms to document and expedite the collection process; reviewing and assessing materials collected for drug use content; and assisting in the preparation of a bibliography of all materials reviewed.

### **4. Jumla Family Planning and Child Survival Project 1994**

The Center for Development and Population Activities, Jumla, Nepal

- Created a focus group discussion tool to determine the most effective family planning service delivery system in a very remote district of Nepal; developed strategies for the integration of family planning and child survival service delivery and the process for implementing those activities.

## **Education**

Master of Public Health in Maternal and Child Health, San Diego State University, California

Bachelor of Science in Biochemistry, California Polytechnic State University, San Luis Obispo, California

## **Languages**

Nepali

## ANNEX 9: RAPID CATCH SUMMARY DATA

#	CATCH Indicators	N/D	%	Confidence Limits <sup>1</sup>	
				No Design Effect	Design Effect of 2
1	Percentage of children age 0–23 months who are underweight (-2 SD from the median weight-for-age, according to the WHO/NCHS reference population)	152/270	56%	± 6%, or between 50% and 62%.	± 8%, or between 48% and 64%.
2	Percentage of children age 0–23 months who were born at least 24 months after the previous surviving child	38/81	47%	± 11%, or between 36% and 58%.	± 15%, or between 32% and 62%.
3	Percentage of children age 0–23 months whose births were attended by skilled health personnel	84/300	28%	± 5%, or between 23% and 33%.	± 7%, or between 21% and 35%.
4	Percentage of mothers with children age 0–23 months who received at least two tetanus toxoid injections before the birth of their youngest child	44/300	15%	± 4%, or between 11% and 19%.	± 6%, or between 9% and 21%.
5	Percentage of children age 0–5 months who were exclusively breastfed during the last 24 hours	49/72	68%	± 11%, or between 57% and 79%.	± 15%, or between 53% and 83%.
6	Percentage of children age 6–9 months who received breastmilk and complementary foods during the last 24 hours	22/66	33%	± 11%, or between 22% and 44%.	± 16%, or between 17% and 49%.
7	Percentage of children age 12–23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday	6/142	4%	± 3%, or between 1% and 7%.	± 5%, or between 0% and 9%.
8	Percentage of children age 12–23 months who received a measles vaccine	17/142	12%	± 5%, or between 7% and 17%.	± 8%, or between 4% and 20%.
9	Percentage of children age 0–23 months who slept under an insecticide-treated net (in malaria risk areas) the previous night.	131/300	44%	± 6%, or between 38% and 50%.	± 8%, or between 36% and 52%.
10	Percentage of mothers with children age 0–23 months who cite at least two known ways of reducing the risk of HIV infection.	0/300	0%	N/A	N/A
11	Percentage of mothers with children age 0–23 months who report that they wash their hands with soap/ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated.	50/300	17%	± 4%, or between 13% and 21%.	± 6%, or between 11% and 23%.

12	Percentage of mothers of children age 0–23 months who know at least two signs of childhood illness that indicate the need for treatment.	43/300	14%	$\pm 4\%$ , or between 10% and 18%.	$\pm 6\%$ , or between 8% and 20%.
13	Percentage of sick children age 0–23 months who received increased fluids and continued feeding during an illness in the past two weeks.	14/205	7%	$\pm 3\%$ , or between 4% and 10%.	$\pm 5\%$ , or between 2% and 12%.

<sup>1</sup> We have used the following formula to calculate the Confidence Limits:  $P = p \pm Z \times \text{the square root of } (pq/n')$ , where  $P$  = the true proportion of the population;  $Z$  = 95% confidence (1.96);  $p$  = the proportion found in the survey;  $q = 1 - p$ ; and  $n'$  = the size of the sample divided by the design effect. As suggested on page 9 in “Writing the KPC Report” of the KPC 2000+ Manual, we have computed each indicator two ways: without the design effect and with a design effect of 2 to account for the potential bias resulting from the use of cluster sampling. Therefore, it can be said for the first indicator that “We are 95% confident that the true proportion of the population is between 48% and 64%. The best estimate for the true proportion of the population is 56%.”

## ANNEX 10: PROVINCIAL HEALTH COORDINATION COMMITTEE (PHCC) TERMS OF REFERENCE

### PROVINCIAL HEALTH COORDINATION COMMITTEES (PCC) Terms of Reference and Organization Version of 22 October 2003

#### A. Purpose

The purpose of the Provincial Health Coordination Committee (PCC) is to coordinate the activities of all stakeholders in achieving MOH priorities, particularly the expanded delivery of the basic package of health services (BPHS). PCCs are expected to:

- Improve quality of the services (in both technical and administrative aspects)
- Meet MOH goals and priorities within the provinces
- Avoid duplication
- Includes skilled, experienced and responsible members
- Improve interaction amongst different stakeholders and their commitments for PCC's decisions
- Ensure feasible, culturally acceptable decisions within health sector
- Ensure equality and equity in health service delivery

#### B. Terms of Reference

1. **Information sharing:** Provide a forum for the MOH and its partner organizations to share information related to service delivery, MOH policies, new initiatives, and any problems and obstacles.
2. **Technical support:** Provide technical support to the Provincial Health Director and Provincial Health Office staff in line with national and international norms.
3. **Coordinate regular reporting system for HMIS:** Coordinate the collection, processing and distribution of HMIS data from facilities in the province.<sup>1</sup>
4. **Draft provincial plan:** Using HMIS data and other information sources to develop a comprehensive (NGO, MOH, private sector) plan for health in the province, and identify financial resources needed to support the plan and submit to MOH Kabul to for review.
5. **Coordinate the expansion of services:** Coordinate the expansion of services with NGOs, MOH and donors, as per the annual provincial work plan.
6. **Identify sites for new health facilities:** As part of the annual work plan process and to ensure the equitable distribution of services, determine the location for the construction of new facilities should be located.
7. **Assign catchment area:** Determine the geographical definition of catchment areas that are the responsibility of specific NGO or MOH clinics and rationalize the distribution of NGO and MOH activities.

---

<sup>1</sup> Protocol for regular reporting system for HMIS to be provided.



**8. Review and approve proposals:** Review all proposals for support to the delivery of health care in the province, and approve of those that are consistent with MOH policy and that support the current provincial health plan.<sup>2</sup>

**9. Monitor NGO activities:** Take an active role in monitoring NGOs' planning and implementation, including reviewing resources being used for health in the province. Refer any problems with coordination to the Governor, MOH, or other appropriate institution.

**10. Participate in emergency response and special activities:** Participate in all stages of emergency response, such as epidemics, and participate in special activities such as immunization campaigns.

**11. Mediate among stakeholders:** Mediate disputes that arise among stakeholders and ensure shared understanding between government and non-governmental organizations.

**12. Coordinate with MOH and Governor:** Provide forum for the coordination of health related activities with the Provincial Governor and the Central MOH.

### **C. Organization and Implementation**

**13. Membership:** The PCC will be chaired by the provincial health director. Standing members will include: Provincial Health Director (PHD), Provincial Health Deputy Director, Provincial HMIS focal person, and one representative from the Provincial EPI Management Team. No more than seven other members will be selected by the standing members for one year terms from the following: international agencies (INGOs, UN and donors) with an office in the province or region, and NGOs active in the province in health services delivery. In addition, there will be one representative from the private health sector. Other concerned NGOs would be invited on a case to case basis and based on the specific topic and issue.

Issues discussed in the meeting will be taken to the provincial level inter-sectoral meeting with all other line ministries for further decisions/actions.

**14. Administrative Support:** Administrative support for the PCC including taking of minutes, drafting of agendas, etc. will be provided by the agency providing capacity building to the PCC. The PCC's might also need to take steps in improving security situation for actors in the health sector.

**15. Frequency of Meetings:** Meetings will take place at least on a monthly basis as agreed to by the members of the PCC. However in case of an emergency, PCC members would need to meet more frequently. The PHD will be responsible to follow up decisions made based on the discussions in the following meeting.

**16. Training:** Members of the PCC, particularly the standing members, will receive training in the responsibilities of the PCC and how to conduct effective meetings and other management functions necessary to achieve the purpose of the PCC.

**17. Decision Making:** Decision making in the PCC meetings will be based on a simple majority of members present and voting. For a vote to be held, ¾ of the PCC members must be present. If fewer members are present, discussions may take place, but voting must be postponed until the next meeting when ¾ of the members are present.

<sup>2</sup> Protocol for proposal review process to be provided. Note: PCC and GCMU will coordinate on this activity.

## ANNEX 11. EXAMPLE OF SUPERVISORY CHECKLISTS (EPI)

### **IMMUNIZATION SUPERVISORY CHECKLIST**

VILLAGE: \_\_\_\_\_

BHU: \_\_\_\_\_

SUPERVISOR: \_\_\_\_\_

DATE OF VISIT: \_\_\_\_\_

---

#### **1. VACCINE STORAGE REFRIGERATOR/ FREEZER.**

- |  |     |
|--|-----|
| 1.1. Is the refrigerator and or freezer in working order?                          | Yes |
| No   |     |
| 1.2. Is there a thermometer in the refrigerator?                                   | Yes |
| No   |     |
| 1.3. Is Temperature Monitoring Chart maintained?                                   | Yes |
| No   |     |
| 1.4. Is the temperature within acceptable range (0-8C)                             | Yes |
| No   |     |
| 1.5. Has DPT vaccine been frozen?  | Yes |
| No   |     |
| 1.6. Is any of the vaccine in stock expired?                                       | Yes |
| No   |     |
| 1.7. Are there frozen ice packs in the refrigerator?                               | Yes |
| No   |     |
| 1.8. Are vaccines in stock properly rotated so the oldest vaccines are used first? | Yes |
| No   |     |
| 1.9. Are vaccine stock registers maintained?                                       | Yes |
| No   |     |
| 1.10. Are vaccines over or under stocked?  | Yes |
| No   |     |
| 1.11. Is the vaccine wastage an acceptable one?                                    | Yes |
| No   |     |

#### **2. STORE/SUPPLIES AND EQUIPMENT.**

- |  |     |
|--|-----|
| 2.1. Are the cold boxes in good working order?         | Yes |
| No   |     |
| 2.2. Are the vaccine carriers in good working order?   | Yes |
| No   |     |
| 2.3. Are the cold packs in good working order?         | Yes |
| No   |     |
| 2.4. Are the thermometers boxes in good working order? | Yes |
| No   |     |



2.5. Is the stand by generator in working order?	Yes
No	
2.6. Are enough syringes in the stock?	Yes
No	
2.7. Are enough needles in the stock?	Yes
No	
2.8. Are enough immunization cards in the stock?	Yes
No	
2.9. Are enough ice packs in the stock?	Yes
No	
2.10. Are enough vaccine carriers in the stock?	Yes
No	
2.11. Are enough thermometers in the stock?	Yes
No	

### **3. SURVEILLANCE.**

3.1. Is the HF incharge responsible for disease surveillance and data collection?	Yes
No	
3.2. Was the last surveillance report submitted on time?	Yes
No	
3.3. Are all surveillance reports submitted for the last 12 months?	Yes
No	
3.4. Are the ages of cases recorded in the health facility records?	Yes
No	
3.5. Is the immunization status of EPI targeted disease cases recorded?	Yes
No	
3.6. Are surveillance forms correctly and completely filled out?	Yes
No	

### **4. RECORDS/DISPLAYS.**

4.1. Is a geographical map of area displayed?	Yes
No	
4.2. Is number of immunization graphically displayed?	Yes
No	
4.3. Is an up-to-date coverage monitor chart in use and displayed?	Yes
No	
4.4. Are immunization posters displayed?	Yes
No	
4.5. Is disease incidence graph/ charts displayed?	Yes
No	
4.6. Is drop out rate displayed?	Yes
No	
4.7. Is under 1 year list easily available?	Yes
No	
4.8. Is list of the pregnant women easily available?	Yes
No	

4.9. Is defaulter list easily available?	Yes
No	

**5. STERILIZATION.**

5.1. Are the sterilizers in good working order?	Yes
No	
5.2. Is 5 minutes high and 15 minutes low heat being practiced in sterilization?	Yes
No	
5.3. Is equipment cool before use?	Yes
No	
5.4. Is washing hands in practice?	Yes
No	
5.5. Are syringes and needles, irrigated and soaked in water after use?	Yes
No	
5.6. Are syringes and needles checked for damage?	Yes
No	

**6. ORGANIZATION.**

6.1. Is vaccination site clean?	Yes
No	
6.2. Is vaccination site shaded?	Yes
No	
6.3. Is vaccination site well lighted?	Yes
No	
6.4. Is the waiting time too long?	Yes
No	
6.5. Is immunization session held in an easily reachable location?	Yes
No	
6.6. Is the timing of immunization session convenient for the community?	Yes
No	
6.7. Is date of the next visit to villages pre-scheduled and announced?	Yes
No	
6.8. Is advance notice given for arrival of vaccinators in villages each time?	Yes
No	

**7. IMMUNIZATION PERFORMANCE/ TECHNIQUE.**

7.1. Is one sterile syringe used for each injection?	Yes
No	
7.2. Is one sterile needle used for each injection?	Yes
No	
7.3. Are used syringes and needles properly disposed of?	Yes
No	
7.4. Are vaccines reconstituted correctly?	Yes
No	

7.5. Is BCG scar checked?	Yes
No	
7.6. Is dose (amount) administered correctly?	Yes
No	
7.7. Is site of immunization correct?	Yes
No	
7.8. Is immunization technique correct?	Yes
No	
7.9. Is any child denied immunization because of contra-indication?	Yes
No	
7.10. Is sterile technique maintained?	Yes
No	
7.11. Does the number of doses of vaccine given correspond with the number of disposable syringes used?	Yes
No	
7.12. Does the number of doses given correspond with used discarded vials?	Yes
No	
7.13. Is immunization injection site properly cleaned?	Yes
No	

## **8. RECORDING.**

8.1. Is age screening done correctly?	Yes
No	
8.2. Is birth date recorded correctly (not age)?	Yes
No	
8.3. Are the dates of immunization recorded in the register correctly?	Yes
No	
8.4. Are children under 1 marked out in the permanent register?	Yes
No	
8.5. Are records of immunization kept in the health facility?	Yes
No	
8.6. Does each child have an individual immunization card (Not family card)?	Yes
No	
8.7. Do the entries of daily register correspond with one of the permanent register?	Yes
No	

## **9. VACCINE HANDLING (VACCINE CARRIER).**

9.1. Are left over open vials discarded?	Yes
No	
9.2. Are unopened, unused vials stored back in refrigerator?	Yes
No	
9.3. Are open vials properly disposed off?	Yes
No	
9.4. Is temperature in vaccine carrier between 0 to 8C?	Yes
No	

9.5. Are DPT vaccines protected from being frozen?	Yes
No	
9.6. Is BCG protected from light?	Yes
No	
9.7. Is diluent cold?	Yes
No	
9.8. Are vaccines within expiration date?	Yes
No	
9.9. Are the labels on vials protected from water?	Yes
No	
9.10. Are vaccines in use kept on foam in vaccine carriers?	Yes
No	

### **10. COMMUNICATION/ HEALTH EDUCATION.**

10.1. Is the date of next dose communicated?	Yes
No	
10.2. Is the need for 3 dose emphasized?	Yes
No	
10.3. Is the possibility of side effects discussed?	Yes
No	
10.4. Is staff's attitude friendly?	Yes
No	
10.5. Is group health education carried out during team's visit?	Yes
No	
10.6. Are visual aids used for health education purposes?	Yes
No	
10.7. Is mother asked to keep immunization card safely?	Yes
No	

### **11. COMMUNITY PARTICIPATION**

11.1. Does the team report to kolkhoz administration the results of their performance?	Yes
No	
11.2. Does the team give the names of defaulters to VHC for follow-ups?	Yes
No	
11.3. Do VHC members participate in recording of births and follow-up of immunization defaulters?	
Yes    No	
11.4. Is the list of new borns in this village known to the team?	Yes
No	
11.5. Are local leaders supportive of immunization activities?	Yes
No	
11.6. Are VHC members involved in planning of immunization sessions?	Yes
No	

**COMMENTS and REMARKS.**

*If any item checked is not satisfactory, elaborate on that and give recommendations for correction. Put your comments item by item under the same numbering in Checklist. Use additional pages if necessary.*


---